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COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION GUIDANCE AND INSTRUCTIONS FY 2009 – FY 2011

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

CFDA No. 93.958

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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Notice to Respondents:

The annual reporting burden for collection of this information is estimated to average 280 hours for a 1-year application, 250 hours for updating a 2-year plan, and 210 hours for updating a 3-year application. This includes the time required for reviewing instructions and preparing the application, requesting waivers and modifications, writing the implementation report, and gathering, maintaining, and reporting the needed data. Comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, should be addressed to: SAMHSA Reports Clearance Officer, Paperwork Reduction Project (0930-0168), Room 7-1045, One Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor or a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is: OMB No: **0930-0168**.

Introduction

The FY 2009 – 2011 Community Mental Health Services Block Grant (MHBG) Application Guidance and Instructions provide specific information needed to develop and submit the required MHBG application (which includes the State plan described in Part C, Section III of this guidance) and annual Implementation Report.

The guidance is based on the existing MHBG statutory authority and provides a foundation for the MHBG to continue to serve as a vehicle for transforming mental health systems to support recovery for adults with serious mental illness (SMI) and children with severe emotional disturbance (SED) through effective community-based services and programs.

States[1] should submit their FY 2009 – 2011 applications based on the standard guidance provided in this guidance. This application consists of five parts:

- Part A reviews context pertinent to the application (including statutory authority, history and goals, and related planning initiatives) and an overview of format and submission requirements.
- Part B outlines the administrative requirements, fiscal planning assumptions, and other special guidance required to submit a complete application.
- Part C provides specific guidance regarding the content of the application. It offers instructions for preparing a description of the State's service system; an analysis of system strengths, needs, and priorities; and a State plan to improve the service system for adults and children separately, including performance goals and action plans to achieve them. The State plan should include a projection of MHBG funds that will be used to support each of the six mental health transformation goals identified in the *Final Report*

[1] Here and throughout this document, the term "State" refers to each of the 50 States, the District of Columbia, and each of the U.S. territories. The term "U.S. territories" means the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of Northern Marianas, the Virgin Islands, Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

of the President's New Freedom Commission on Mental Health. As in FY 2008, States are expected to report on all mental health national outcome measures (NOMS) related to mental health.

- Part D provides guidance on how to prepare and submit the annual Implementation Report, which describes the extent to which the State has implemented its plan submitted in the prior year.
- Part E provides guidance on submission of the Uniform Reporting System (URS) data tables.

In addition, this guidance includes several required attachments and appendices that provide useful resource information for the plan.

PART A. Context and Overview of the FY 2009 – 2011 MHBG Application

I. Statutory Authority

Under the authority of the Public Health Service Act (PHS Act)[2] and subject to the availability of funds, the Secretary of the Department of Health and Human Services (HHS), through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), awards Community Mental Health Services Block Grants (MHBGs) to States to establish or expand an organized community-based system for providing mental health services for adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED).

In order for the Secretary to award a MHBG, a State must submit an application, prepared in accordance with the law for the fiscal year for which the State is seeking funds. The funds awarded are to be used to carry out the State plan contained in the application; to evaluate

[2] Sections 1911-1920 of the PHS Act (42 USC 300x-1through 300x-9) and Sections 1941-1956 of the PHS Act (42 USC 300x-51 through 300x-66). A complete copy of the PHS Act may be found at http://energycommerce.house.gov/108/pubs/109_health.pdf.

programs and services set in place under the plan; and to conduct planning, administration, and educational activities related to the provision of services under the plan.[3]

A grant may be made only if the application includes a State plan that meets five (5) specific criteria articulated in the statute and is approved by the Secretary.[4] The State is required to provide any data required by the Secretary pursuant to the statute and cooperate with the Secretary in the development of uniform criteria for the collection of data.[5]

In addition, the Secretary may award a grant for a State's full allotment only if the Secretary determines, after review of the State plan implementation report for the prior fiscal year, that the State has completely implemented the approved State plan for the prior fiscal year. If the Secretary determines that a State has not completely implemented the prior year's plan, the Secretary shall reduce the amount of the State's block grant allotment for the fiscal year by 10 percent.[6]

The application must be submitted in the form and manner determined by the Secretary and must contain such agreements, assurances, and information as the Secretary determines to be necessary to carry out the MHBG program.[7] This MHBG Guidance provides information to assist States in completing and submitting their applications.

This MHBG Guidance has been developed based on current statute. The Agency is aware that Congress is currently considering legislation to reauthorize SAMHSA. The reauthorization bill proposes substantive changes to the MHBG that would affect this Guidance. Upon passage of reauthorization legislation, CMHS will contact States to provide additional guidance that may be needed to complete the MHBG application and Implementation Report. If significant changes to MHBG requirements, State plans, or data collection are included in the final reauthorization law, CMHS may revise and re-submit this guidance for public comment through the Federal Register.

[3] Section 1911 of the PHS Act (42 USC 300x-1).
[4] Section 1912 (a)-(b) of the PHS Act (42 USC 300x-2).
[5] Section 1943(a)(3) of the PHS Act (42 USC 300x-53).
[6] Section 1912(d)(1) of the PHS Act (42 USC 300x-2)
[7] Section 1917(a)(7) of the PHS Act (42 USC 300x-6).

II. History and Goals of the MHBG

The MHBG is designed to support States in reducing their reliance on psychiatric inpatient services and to facilitate the development of effective community-based mental health services and programs for adults with SMI and children with SED. This program has the following specific goals:

- To ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental services, and health services, as well as mental health services and supports;
- To promote participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- To ensure access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- To promote recovery and community integration for adults with SMI and children with SED;
- To increase accountability through uniform reporting on access, quality, and outcomes of services.

The MHBG evolved out of a 45-year history of support by the Federal government to the States for the development of community-based services for people with mental illnesses. In 1963, the Community Mental Health Centers (CMHC) Act was adopted to support the development of comprehensive mental health services in local communities. In 1981, support provided under the CMHC Act was converted into a block grant – the MHBG – that was administered by the National Institute of Mental Health and provided a flexible source of funding to States to support community services. In 1992, Congress passed legislation-moving responsibility for administration of the MHBG to the Center for Mental Health Services (CMHS), part of the newly formed Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS).

The MHBG's historical emphasis on transforming mental health systems to facilitate the development of effective community-based services was reinforced in 2003 with the release of the *Final Report* of the President's New Freedom Commission on Mental Health. The landmark report called for a complete transformation of the mental health system, to be achieved through a concerted attempt to accomplish six specific goals. Its authors envisioned "a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community." The MHBG continues to provide an important vehicle through which States can implement this vision.

III. Related Planning and Assessment Initiatives

CMHS recognizes that sound and effective planning is the foundation for goal achievement, and that assessment makes it possible to address deficiencies and build on accomplishments. The following initiatives are particularly relevant to the MHBG.

A. OMB Program Assessment Rating Tool (PART)

In an effort to improve program accountability and ensure fiscal responsibility for Federally-funded programs, the Office of Management and Budget (OMB) created the Program Assessment Rating Tool (PART). The PART, which is one component of the Federal government's effort to hold agencies accountable for their funded programs, assesses four aspects of each program:

1. *Program purpose and design:* the extent to which the program design and purpose are clear and defensible;
2. *Strategic planning:* whether the agency sets valid annual and long-term goals;
3. *Program management:* agency management of the program, including financial oversight and program improvement efforts; and
4. *Program results:* actual program performance in achieving the goals identified in the strategic planning section of the PART.

The MHBG was evaluated using the PART in FY 2003 for the 2005 budget cycle and received a rating of adequate. In annual updates to OMB, the MHBG Program has been encouraged to continue improving its data collection on program performance in order to help assure appropriate use of program funds and to enhance planning for community-based systems of care for adults with SMI and children with SED.

B. National Outcome Measures (NOMS)

Accountability in the delivery of quality mental health services for adults with SMI and children with SED continues to be a guiding principle of the Federal planning process for the MHBG. CMHS has established that one level of accountability will be measured by the collection of standardized data from States using uniform national outcome measures (NOMS)8 and other State- identified measures that reflect the priorities and needs of individual States. The NOMS and related performance indicators are described in Exhibit 3 of this guidance. The NOMS are derived from tables in the Uniform Reporting System (URS), described in Part E of this guidance. The URS tables are located in Appendix II.

To assist States in data collection activities, Data Infrastructure Grants (DIGs) were first offered to States in FY 2001. The DIGs are expected to support States in reporting uniform data that can be aggregated on a national basis. In FY 2004, States received the second set of DIGs, substantially improving their ability to collect and report NOMS. DIG funding was made available for the third time in FY 2008. All States that accepted a DIG are required to submit data on the URS tables using the uniform definitions and methods agreed to by the States.

Through monthly workgroup meetings with State staff, the MHBG Program continues to work with States to refine and operationalize the NOMS contained in the URS data tables. When developed, SAMHSA will submit additional instructions and expectations regarding the actual reporting of these NOMS separately to the States. All States are expected to report on all mental health NOMS.

[8]Profiles and performance information for each State and Territory are posted to SAMHSA's Web site (www.nationaloutcomemeasures.gov).

C. Web Block Grant Application System (WebBGAS)

WebBGAS is a Web-enabled block grant management system that allows for the submission, review, and archive of MHBG application and Implementation Report. Beginning in FY 2008, all States were requested to use this system to submit MHBG applications and Implementation Reports.

WebBGAS benefits both States and the Federal government by significantly reducing the paperwork burden required for submission, revision, and reporting. The electronic system facilitates the preparation of required documents in the following ways:

- Eliminates redundant data entry by automatically pre-populating tables with previously entered data.
- Allows multiple State Planners to work on different sections of the application or Implementation Report at the same time.
- Integrates documents originally written in Microsoft Word, Microsoft Excel, WordPerfect, or PDF when files are uploaded through WebBGAS.
- Reduces the overall reporting burden associated with submitting the application and Implementation Report.

This form of submission also facilitates the process of sharing and analyzing State plans and Implementation Reports. For example, electronic standardization of the data set allows for the production of streamlined reports and quantitative analysis on a national level. The application and Implementation Reports may be viewed by State users, Planning Council Chairs and members, State citizens, and Federal staff. In addition, once the application or Implementation Report document has been generated, it may be viewed, searched, or printed with Adobe Acrobat.

The Web site for WebBGAS is: https://bgas.samhsa.gov

D. SAMHSA Data Strategy

The 2007—2011 *SAMHSA Data Strategy* has just been released to the public. Goal 2 of the Data Strategy specifically deals with performance data and includes specific milestones for the next few years, including the development of client-level outcome measures for the states by 2011. CMHS may revise this guidance to reflect the adoption of client level measures for future block grant applications if sufficient progress is made over the next three years. If this occurs, CMHS will re-submit this guidance for public comment.

IV. Application Format

As directed by the MHBG statute,[9] all applications must include a State plan that addresses the five (5) criteria articulated in the statute. Criteria 1, 2, 4 and 5 must be addressed for adults with SMI, and Criteria 1-5 must be addressed for children with SED (with the exception of the reference to older adults in criterion 4). The criteria are listed below in Exhibit 1. States should submit a single plan in which services for adults with SMI and children with SED are addressed separately.

States have the option of submitting 1-, 2-, or 3-year plans. Specific instructions for each plan are provided below.

A. Application Overview for All MHBG Applications Beginning in FY 2009

In preparing applications for FY 2009 - 2011, States should use this Application Guidance and Instructions, regardless of whether a State submits a single year or a multi-year application.
The application must include:

- Face Sheet.
- Table of Contents.
- Executive Summary.
- All items in Part B.
- All items in Part C.

[9] Section 1912 of the PHS Act (42 USC 300x-2).

1. Guidance Specific to 1-Year Applications

One-year applications for FY 2009 – FY 2011 are due according to the following schedule:

Fiscal Year Application	**Due Date**
FY 2009	September 2, 2008
FY 2010	September 1, 2009
FY 2011	September 1, 2010

The Implementation Report (Parts D & E of this guidance) for FY 2008 is due December 1, 2008. The Implementation Report will describe the extent to which the State implemented its State plan for FY 2008 and will include data from the Uniform Reporting System (URS Tables).

2. Guidance Specific to 2-Year or 3-Year Applications Submitted in FY 2009

States submitting 2-year and 3-year applications must ensure that the plan clearly documents goals, targets, and funding plans for each year covered by the State plan. See Part C, Section III of this document for specific guidance on reporting requirements. Otherwise, requirements are identical to those of 1-year applications (see above).

3. Guidance Specific to Approved 2-Year or 3-Year Applications

If a multi-year application is approved, the State is not required to resubmit Part C, Section I in subsequent years covered by the application unless the State's public mental health system has substantially changed or the State Mental Health Authority's responsibilities change within the State's organizational structure. Only *modifications and changes* to Part C, Sections II and III must be submitted annually with the State's application. The updates should describe changes in critical gaps and unmet needs, identify significant achievements reflecting progress towards development of a comprehensive community-based mental health system, and document any changes in the original goals and targets. All performance indicator tables must be updated each year to include narrative as needed.

4. Notification of Changes

States with approved **multi-year applications** are expected to ensure that their State plans are updated to reflect the current status of their mental health systems. It is important that the

MHBG Program be notified of changes made in the State's mental health system after the application has been submitted through a written modification submitted to SAMHSA's Division of Grants Management Office. Before submitting application updates each year, States should assess the impact of any positive or negative changes that occurred in the previous year that will affect the State's ability to carry out the proposed State plan. If changes are necessary, States may modify the plan as part of the State's application update.

Similarly, States with approved **1-year applications** are advised to report changes that will affect the State's ability to carry out the proposed State plan. A written modification describing such changes should be submitted to SAMHSA's Division of Grants Management Office.

Any State modifying a previously approved application – whether 1-year or multi-year – should *identify specific changes* by referring to page numbers of the original application, rather than simply making changes to the original application and resubmitting it. The modifications should be discussed in detail within the context of the affected criteria, goals, and targets and submitted to SAMHSA's Division of Grants Management Office. After notifying both the Grants Management Office and the Federal Project Officer, changes to the application may be entered into WebBGAS.

PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance

I. Federal Funding Agreements, Certifications and Assurances, and Requirements

Federal funding agreements, certifications, assurances, and other requirements are necessary each year in order for States to receive MHBG funds. These include the following:

A. Data Universal Numbering System (DUNS) Number (Face Sheet)

A DUNS number is a unique 9-digit number required for all applicants for Federal grants and cooperative agreements, with the exception of individuals other than sole proprietors. The

number is used to identify related organizations that receive funding under grants and cooperative agreements, and to provide consistent name and address. The DUNS Number should be entered on the Face Sheet of the State's Plan/Application.

B. Funding Agreements (Attachment A)

Do not retype the Funding Agreement; this may require resubmission of the agreement, which could delay the award of funds. The Chief Executive Officer (Governor) or a formal designee must sign the statutory funding agreements, hereby attesting that the State will comply with them. If the funding agreements are signed by a designee, a letter from the Governor authorizing the person to sign must be included with the application.

C. Certifications – PHS 5161-1 (Attachment B) - (OMB Approval 0920-0428)

Do not retype any of the certifications; this may require resubmission of a certification, which could delay the award of funds. The following certifications must be submitted:

1. Debarment and Suspension

A fully executed Debarment and Suspension Certification must be included.

2. Drug-Free Workplace Requirements

A fully executed certification regarding Drug-Free Workplace Requirements must be included with the application unless the State has an acceptable FY 1997 Statewide or Agency-wide certification on file with the Department of Health and Human Services. Federal regulations regarding these requirements are found in 45 CFR Part 76.

3. Lobbying and Disclosure

A fully executed Lobbying Certification must be included for all awards exceeding $100,000. This certification must be signed by the Chief Executive Officer of the State (Governor) or his/her formally authorized designee. Additional information about this requirement can be found in 45 CFR Part 93.

Included in the Application Guidance and Instructions is a copy of Standard Form-LLL "Disclosure of Lobbying Activities" and instructions to report lobbying activities. It may be downloaded from this site: http://mhbg.samhsa.gov/disclosure.pdf

4. Program Fraud Civil Remedies Act (PFCRA)

5. Environmental Tobacco Smoke

D. Assurances SF 424B (Attachment C) - (OMB Approval 0348-0040)

Do not retype any of the assurances; this may require resubmission of the assurance(s), which could delay the award of funds.

II. Reports on Set-Aside for Children's Mental Health Services

A. Verification of Minimum Spending Level

States are required to provide systems of integrated services for children with SED.[10] Each year the State shall expend not less than the amount expended in FY 1994. States are required to verify their compliance with this requirement by reporting the following information:

State Expenditures for Mental Health Services

Reported by: **State FY _____** **Federal FY_____**

Actual FY 1994	Actual FY 2007	Estimated/Actual FY 2008
$	**$**	**$**

B. Waiver of Children's Mental Health Services

If there is a shortfall in funding available for children's mental health services, the State may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with SED, as

[10]Section 1913(a) of the PHS Act (42 USC 300x-3).

indicated by comparing the number of children in need of such services with the services actually available within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. Maintenance of Effort (MOE) Report

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory maintenance of effort (MOE) requirements.[11] MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant. The State shall only include community mental health services expenditures for individuals that meet the federal or state definition of SMI adults and SED children. States that received approval to exclude funds from the maintenance of effort calculation should include the appropriate MOE approval documents.

States are required to submit expenditures in the following format:

State Expenditures for Mental Health Services

MOE reported by: **State FY _____Federal FY_____**

Actual FY 2006	Actual FY 2007	Estimated/Actual FY 2008
$	**$**	**$**

A. MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principal agency for authorized activities of a non-recurring nature and for a specific purpose.[12] A request for an MOE exclusion should meet the following requirements:

[11]Section 1915(b)(1) of the PHS Act (42 USC 300x-4).
[12]Section 1915(b)(2) of the PHS Act (42 USC 300x-4).

- The State shall request the exclusion separately from the application.
- The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer.
- The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.
- The State may not exclude funds from the MOE calculation until such time as the SAMHSA Administrator has approved in writing the State's request for exclusion.

B. MOE Shortfalls

States are expected to meet the MOE requirement. If a State cannot meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

1. Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the State Fiscal Year in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent.

2. Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: (1) whether the State maintained service levels; (2) the State's mental health expenditure history; and (3) the State's future commitment to funding mental health services.

IV. Fiscal Planning Assumptions

If the final allocation for the MHBG for the fiscal years covered by the State plan is not available at the time of the preparation of this application, the intended use of the funds described in the State plan should be based on the amount of the allocation made to the State for the prior fiscal year. For FY 2009, States are expected to develop their intended use of funds based on their FY 2008 MHBG allocation. States that are submitting multi-year plans in FY 2009 are not required to provide this information for FY 2010 or FY 2011. These States are expected to submit their intended use of funds for FY 2010 and FY 2011 in their annual updates. The intended use of funds should be based, if necessary, on the MHBG allotment for the prior fiscal year.

Each year, upon enactment of the Federal budget for the fiscal year, States will receive an annual allotment table. If the new annual allotment is significantly increased or decreased, the State may be required to modify the intended use of funds that was submitted in the application.

Funds awarded under the MHBG must be obligated and expended within a 2-year period. For the FY 2009 MHBG award, the period is October 1, 2008 through September 30, 2010. States also are required to submit a Financial Status Report (SF 269 Short Form) 90 days after the end of the obligation and expenditure period.

The PHS Act provides specific restrictions regarding the use of MHBG funding. Funds may not be used for any of the following purposes:

- To provide inpatient hospital services;
- To make cash payments to intended recipients of health services;
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) and building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; and
- To provide financial assistance to any entity other than a public or nonprofit private entity. (This prohibits use of MHBG funds to award grants/financial assistance to for-profit organizations but does not prohibit States from entering into a contractual agreement with for-profit organizations.)

States may spend up to 5 percent of their grant for administrative expenses with respect to the grant.

V. Submission Requirements and Due Dates

This guidance, *Community Mental Health Services Block Grant Guidance and Instructions, FY 2009 – 2011*, is available at the SAMHSA Web site at www.mhbg.samhsa.gov. In FY 2009, State applications may be submitted via WebBGAS or to the following address:

Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857 (for overnight/express mail, use zip code "20850")

If the application is submitted using WebBGAS, States must also mail an original and two copies of **Part B, Section I** (required Funding Agreement and other signature documents) and the signed copy of the Mental Health Planning Council letter to the SAMHSA Grants Management

Office. Other sections of the application should not be submitted in hard copy if they have been submitted using WebBGAS.

If a State does not use WebBGAS and submits its application in hard copy, it must submit the original and two copies of the **entire application** to the above address.

If the State's application is submitted in hard copy, the original and copies should be submitted unbound, without staples, paper clips, or fasteners. Do not attach or include any folded material, pasted, or in a size other than 8½" x11" on white paper. Heavy or lightweight paper should not be used, and submissions should be printed only on one side. Do not condense type closer than 15 characters per inch. Each sheet of the application should be numbered consecutively from beginning to the end (for example, number the face sheet as page 1). Any appendices or additional materials included should be numbered continuing the same sequence.

The Federal statute stipulates that applications must be received by September 1 and that Implementation Reports must be received by December 1.[13] If the due date falls on a weekend or Federal holiday, the application will be due on the next business day. Since the due dates are established in statute, waivers may not be given.

For FY 2009, applications must be received by September 2, 2008. Implementation Reports for FY 2008, including the URS Tables, must be received by December 1, 2008.

Should you need additional information regarding submission of the application, contact Barbara Orlando at (240) 276-1422, Barbara.Orlando@samhsa.hhs.gov. Questions regarding the MHBG program should be directed to your Federal Project Officer at (240) 276-1740.

VI. State Mental Health Planning Councils

The statute establishing the MHBG requires States that receive block grant funds to "establish and maintain" State Mental Health Planning and Advisory Councils (Planning Councils).[14] State Planning Councils are partners to the State in achieving the goals of the MHBG (described in

[13]Section 1917(a) of the PHS Act (42 USC 300x-6).
[14]Section 1914(b) of the PHS Act (42 U.S.C. 300x-4).

Part A, Section II of this guidance). CMHS encourages States to involve Planning Council members at all levels of decision making to ensure that community-based services are consumer- and family-driven and that they are responsive to the needs of adults with SMI and children with SED.

The MHBG statute articulates specific duties and responsibilities of Planning Councils, which are described below.

A. Responsibilities of State Mental Health Planning Councils

By Federal law, State Planning Councils have the following duties:

1. Review State plans and submit any recommended modifications to the State;

2. Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and

3. Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

B. Membership Requirements

State Mental Health Planning Councils are required to conform to certain membership requirements. Councils must include representatives of certain principal State agencies;[15] other public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related services; adults who are current or former consumers of mental health services; family members of adults with SMI and children with SED; and representatives of organizations of individuals with mental illness and their families, or community groups advocating on their behalf. Specifically, the law stipulates that not less than 50 percent of the members of the planning Council must be individuals who are not State employees or providers of mental health services. The law also requires that the ratio of parents

[15] The principal State agencies are those with responsibility for mental health, Medicaid, vocational rehabilitation, housing, social services, and criminal justice.

of children with SED to other members of the Planning Council be sufficient to provide adequate representation of such children in the deliberations of the Council. [16]

To demonstrate compliance with the statutory membership requirements, States should complete Tables A and B for the current fiscal year. In the Table A column, "Type of Membership," indicate whether a member is a consumer, a family member of a child with SED, a family member of an adult with SMI, a provider, a state employee, or a representative not otherwise stated in the legislation. In order to comply with statutory requirements regarding the composition of Planning Councils, the State should identify **one** primary role for each member, even if that member's contributes to the Council in ways that reflect more than one type of membership.

C. State Mental Health Planning Council Comments and Recommendations

Each State application and Implementation Report should include documentation that they were shared with the Planning Council. Any recommendations for modifications to the application or comments to the Implementation Report that were received from the Planning Council must be submitted to CMHS, regardless of whether the State has accepted the recommendations. The documentation, preferably in a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and Implementation Report.

D. Public Comment on the State Plan

The MHBG statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan.[17] States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. States should describe their efforts and procedures to obtain public comment on the plan in this section.

[16] Section 1914(c) of the PHS Act (42 USC 300x-4).
[17] Section 1941 of the PHS Act (42 USC 300x-51).

TABLE A. List of Planning Council Members

NAME	TYPE OF MEMBERSHIP*	AGENCY OR ORGANIZATION REPRESENTED*	ADDRESS, PHONE & FAX	EMAIL ADDRESS (IF AVAILABLE)

*Council members should be listed *only once* by type of membership and agency/organization represented. See "type of membership" in Table B.

TABLE B. Planning Council Composition by Type of Member

TYPE OF MEMBERSHIP	NUMBER	PERCENTAGE OF TOTAL MEMBERSHIP
TOTAL MEMBERSHIP		
Consumers/Survivors/Ex-patients (C/S/X)		
Family Members of Children with SED		
Family Members of Adults with SMI		
Vacancies (C/S/X & family members)		
Others (Not state employees or providers)		
TOTAL C/S/X, Family Members & Others		
State Employees		
Providers		
Vacancies		
TOTAL State Employees & Providers		

Note:

1. The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council.
2. State employee and provider members shall not exceed 50 percent of the total members of the Planning Council.
3. Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.

PART C. Specific Guidance for State Applications

I. Description of the State Service System

In Section I of the application, the State is requested to describe the organizational structure through which mental health services are provided. In describing the mental health system, States should identify any new policy issues or developments that would help explain the context for mental health service delivery in the State. Specifically, this section should include the following:

- *Overview of the State's mental health system:* Describe how the public mental health system is currently organized at the State and local levels. This description should include a discussion of the roles of the State Mental Health Agency and other State agencies with respect to the delivery of services that affect people with mental illnesses. States should also include a description of regional, county, and local entities that provide mental health services or contribute resources that assist in providing the services.
- *Role of the State Mental Health Agency:* Describe how the State mental health agency provides leadership in coordinating mental health services within the broader system.
- *Legislative initiatives and changes*: Describe any recent legislation or other policy changes that have affected how services are provided.
- *Other new developments and issues:* Describe any other recent changes that affect mental health service delivery in the State, such as those related to Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP), or contracting arrangements.

Sections II and III require States to provide separate discussions of services provided to adults and services provided to children. Section 1912(b) of the Public Health Act (42 USC 300x-2) establishes five criteria that must be addressed in state mental health plans. The adult and children's discussions in Sections II and III should be organized according to the applicable statutory criteria. The criteria are defined below in Exhibit 1.

Exhibit 1. Statutory Criteria to be Addressed in the State Plan

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders.
- Describes available services and resources within a comprehensive system of care, provided with Federal, State, and other public and private resources, in order to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. These shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services;
  - Housing services;
  - Educational services;
  - Substance abuse services;
  - Medical and dental services;
  - Support services;
  - Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA);
  - Case management services;
  - Services for persons with co-occurring (substance abuse/mental health) disorders; and
  - Other activities leading to reduction of hospitalization.

Criterion 2: Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 3: Children's Services

- Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include:
  - Social services;
  - Educational services, including services provided under IDEA;
  - Juvenile justice services;
  - Substance abuse services; and
  - Health and mental health services.
- Establishes defined geographic area for the provision of the services of such system.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

- Describes the State's outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals in rural areas; and
- Describes how community-based services are provided to older adults.

Criterion 5: Management Systems

- Describes financial resources, staffing, and training for mental health services providers necessary for the plan;
- Provides for training of providers of emergency health services regarding mental health; and
- Describes how the State intends to expend this grant for the fiscal years involved.

II. Identification and Analysis of System Strengths, Needs, and Priorities

In Section II of the application, States are requested to identify and analyze the strengths, needs, and priorities of the State's mental health service system. The purpose of this section is to present the rationale for the State's approach to improving services for adults and children.

As discussed above, States should provide separate analyses for services provided to adults and children, using the five criteria established in law to structure each discussion (see Exhibit 1 above). The discussion of services for adults should address all criteria except Criterion 3, which does not apply to adult services. The discussion of services for children should address all criteria, except that the discussion of Criterion 4 should not address services for older adults. Narratives should fully address all sub-points provided for each criterion. To avoid repeating identical information in different sections of the application or in the separate discussions provided for adult and children's services, States are encouraged to add references to other relevant sections of the application as needed.

Each discussion (for adults and for children) should address the following:

- The strengths and weaknesses of the service system;
- Unmet service needs and critical gaps within the current system, including identification of data sources used to identify the needs and gaps;
- The State's priorities and plans to address unmet needs and critical gaps;
- Recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care; and
- A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

III. State Mental Health Plan

Section III of the application is the State mental health plan. Building on the strengths, needs, and priorities identified in Section II, this section provides both a description of the mental health

services provided in the State and a plan for improving services that includes performance goals and action plans.

States should provide separate plans for adults and children, using the five criteria established in law to structure each discussion (see Exhibit 1). As discussed above, the plan for adults will address all criteria except Criterion 3, which does not apply to adult services. The plan for children will address all criteria except that the discussion of Criterion 4 should not address services for older adults. To avoid repetition in information provided in Sections II and III and/or adult and children's plans, States are encouraged to include references to other relevant sections of the application as needed.

Each plan will contain three parts: (A) a description of services provided in the State; (B) performance goals, targets, and action plans for improving services; and (C) a table and narrative describing how the MHBG supports mental health transformation in the State. Requirements for each of these sections are discussed below.

A. Description of Services

For each applicable criterion, States should describe how services are provided to adults with SMI and children with SED. Narratives should fully address all sub-points provided for each criterion. Additional guidance to address each service will be provided in WebBGAS.

B. Performance Goals, Targets, and Action Plans

This section describes specific outcome measures and performance indicators that inform State planning efforts, as well as action plans designed to address issues identified by these data collection efforts.

Specific requirements for this section are described in Subsections 1 and 2, below. For each indicator in these subsections, States are required to provide actual data for the past two years (to

the extent that it is available), projected data for the current year, and a specific target for the next year (and subsequent years if submitting a multi-year plan).

The table format for presenting indicators in Subsections 1 and 2 is shown in Exhibit 2 below. Tables in WebBGAS also are presented in this format. In addition to data elements shown in the sample table and defined in the section titled "Table Descriptors," States are requested to provide a brief explanatory narrative. Elements to be addressed in this narrative also are listed below.

Exhibit 2. Sample Performance Indicator Table for State Plan

Name of Performance Indicator:						
Population:			**Criterion:**			
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	**FY2006 Actual**	**FY 2007 Actual**	**FY2008 Projected**	**FY2009 Target**	**FY 2010* Target**	**FY 2011* Target**
Performance Indicator (Value)						
Numerator**			---	---	---	---
Denominator**			---	---	---	---

Please Note:

* Targets for FY 2010 & FY 2011 are required only for multi-year plans.

** Numerator and Denominator are not required for Projected Data or Targets.

Table Descriptors

- **Name of Performance Indicator**: Brief name of the performance indicator. (e.g., Increased Access to Services). Clearly label transformation outcome measures.

- **Projected**: Enter projected data for fiscal year if actual data is not yet available.

- **Target:** A specific measurable and expected outcome to be achieved within a defined period of time, and if attained, is expected to contribute to the realization of the goal.

- **Performance Indicator Value**: Numerator divided by the Denominator expressed as percentage or actual number if not percentage.

Narrative Elements

- **Goal**: Broad, general description of what the States hopes to accomplish.

- **Target**: A specific measurable and expected outcome to be achieved within a defined period of time, and if attained, is expected to contribute to the realization of the goal.

- **Population**: Group targeted by the goal.

- **Criterion**: One or more of the five statutory criteria related to this goal.

- **Indicator**: Description of the indicator.

- **Measure**: Specify whether the performance indicator is measured by number or percentage.

- **Sources of Information**: Databases from which data was reported.

- **Special Issues**: Any special issues or considerations that relate to the indicator.

- **Significance**: Importance of indicator to the overall State Plan.

- **Action Plan**: Activity or activities to be undertaken to achieve the target.

1. National Outcome Measures (NOMS) and Other Performance Indicators

In partnership with the States, SAMHSA identified a set of national outcome measures (NOMS) and related performance indicators that are relevant to State mental health systems. The measures are described at Exhibit 3 below. The NOMS are intended to increase accountability and provide a comprehensive State-by-State picture of mental health and substance abuse service results. SAMHSA also uses NOMs data to organize technical assistance to States around monitoring and improving quality. States are expected to integrate the NOMS and related performance indicators into their MHBG planning process.

Within each criterion, States should discuss the relevant NOMS. Targets for NOMs are required for each year indicated in the State plan. In addition, States are encouraged to report on any additional State-specific indicators the State finds useful for tracking improvements in the public mental health system.

All States are expected to report on all mental health NOMS, which are described at Exhibit 3, below. **Additional information regarding reporting on the NOMS, including the specific numerator and denominators to be used, is provided at Appendix 1.** If a State is unable to report on a measure, the State should provide a narrative explanation in the State plan and Implementation Report. The narrative explanation should include the following components: (1) the current status of the capacity to collect this data; (2) efforts underway to make collection of the data possible; and (3) a projected date for when the data will be available. SAMHSA and the States currently are collaborating in an ongoing effort to refine the specific components of several measures, and SAMHSA will continue to provide information and instructions to reflect those changes.

SAMHSA and the States currently are collaborating in an ongoing effort to refine the NOMS and the data tables from which they are derived. SAMHSA will provide information and instructions to the States to reflect any changes to the URS tables or NOMS that result from this effort.

Exhibit 3. National Outcome Measures (NOMS) and Related Performance Indicators

Outcome	Mental Health Indicator	Relevant Criterion	DIG/URS Tables	Required by PART*
1. Increased Access to Services (Service Capacity)	Number of Persons Served by Age, Gender, and Race/Ethnicity	Criteria 2 and 3	Tables 2A and 2B	Yes
2. Reduced Utilization of Psychiatric Inpatient Beds	Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 30 days and 180 days	Criteria 1 and 3	Table 20A	Yes
3. Use of Evidence-Based Practices	Percent of SMI and SED Clients Receiving EBPs	Criteria 1 and 3	Tables 16 and 17	Yes
	Number of EBPs Offered	Criteria 1 and 3	Tables 16 and 17	Yes
4. Client Perception of Care	Percent of Clients Reporting Positively About Outcomes	Criteria 1 and 3	Table 11	Yes
5. Increased/Retained Employment or Return to/Stay in School	Percent of Adult Clients Who are Competitively Employed	Criterion 1	Table 4	No
	Percent of Parents Reporting an Improvement in Child's School Attendance	Criteria 1 and 3	Table 19B	No
6. Decreased Criminal Justice Involvement	Percent of Clients Arrested in Year 1 Who Were Not Re-Arrested in Year 2	Criteria 1 and 3	Table 19A	No
7. Increased Stability in Housing	Percent of Clients Who Are Homeless or in Shelters	Criteria 1 and 3	Table 15	No
8. Increased Social Supports/Social Connectedness	Percent of Clients Reporting Positively About Social Connectedness	Criteria 1 and 3	Table 9	No
9. Improved Level of Functioning	Percent of Clients Reporting Positively About Functioning	Criteria 1, 3, and 4	Table 9	No

* This column indicates whether the specific performance indicator is required by the Office of Management and Budget (OMB) as a result of the Program Assessment Rating Tool (PART). PART is described in more detail in Part A, Section III (A) of this guidance.

2. State Transformation Outcome Measure

States are required to identify at least one State-specific mental health transformation outcome measure and to report a performance indicator related to the measure. States may choose to identify one or more of the NOMS or other State-specific indicators as transformation outcome measures or may identify one or more transformation outcome measures in addition to these.

C. Transformation Activities

In this section, States are requested to provide information describing how MHBG funding is used to support mental health transformation activities. States are encouraged to complete Table C below, which describes the extent to which the State uses the MHBG to implement specific transformation goals defined by the President's New Freedom Commission on Mental Health.

For each mental health transformation goal provided in Table C, please briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Table C. MHBG Funding for Transformation Activities

Goals	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check.	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY2009.	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health			
GOAL 2: Mental Health Care is Consumer and Family Driven			
GOAL 3: Disparities in Mental Health Services are Eliminated			
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice			
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated *****			
GOAL 6**:** Technology Is Used to Access Mental Health Care and Information			
Total MHBG Funds	*N/A*		

***** Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: *Excellent Mental Health Care is Delivered and Research is Accelerated*. CMHS is authorized to conduct evaluations of programs and not research.

PART D. Implementation Report

The Federal statute requires the Secretary of HHS to determine the extent to which States have implemented the State plan (which is described in Part C, Section III of this guidance) for the prior fiscal year. [18] The purpose of the Implementation Report is to provide information to assist the Secretary in making this determination.

[18] Section 1912(d)(1) of PHS Act (42 USC 300x-2).

States are requested to prepare and submit their Implementation Reports for the last completed fiscal year in the format provided in this guidance. The report will address the purposes for which the MHBG monies were expended**,** the recipients of grant funds, and the activities funded.[19] Particular attention should be given to the progress made toward accomplishing the goals and performance indicators identified in the plan. As described in Part B, Section VI of this guidance, the Implementation Report should also contain any comments from the State Planning Council,[20] preferably in the form of a letter. The Uniform Reporting System (URS) Data Tables presented in Part E also must be included as a component of the Implementation Report.

All States are requested to use WebBGAS to submit Implementation Reports. If sending hard copies, mail the original and two copies to:

LouEllen M. Rice
Grants Management Officer
Division of Grants Management
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857 (for overnight/express mail, use zip code "20850")

As noted in Part B, Section V of this guidance, the Implementation Report *must* be received by SAMHSA by December 1 in order for the State to receive a grant for the following fiscal year. If the due date falls on a weekend or Federal holiday, the application will be due on the next business day. The following schedule provides specific due dates for annual Implementation Reports:

Implementation Report	**Due Date**
FY 2008	December 1, 2008
FY 2009	December 1, 2009
FY 2010	December 1, 2010
FY 2011	December 1, 2011

[19] As required by Section 1942(a)(1) and (2) of PHS Act (42 U.S.C. 300x-52).
[20] As required by Section 1915(a)(2) of PHS Act (42 USC 300x-4).

I. Report Summary

In the first section of the Implementation Report, States are requested to provide a concise overview of how the plan was implemented and the context in which it occurred. This should include:

- A brief review of areas that the State identified in Section II of the application submitted during the previous year as needing improvement and progress made toward addressing those areas;
- The most significant events that affected the mental health system of the State during the implementation period covered by the report, including the impact of these events on the implementation plan;
- Any significant changes from the plan that occurred during implementation; and
- A concise overview of the purposes for which the block grant monies were expended, the recipients of grant funds, and activities funded, including highlights of accomplishments.

II. Performance Indicators and Accomplishments

In the second section of the report, States are required to complete the Performance Indicator Tables for the Implementation Report. Performance indicators should be reported using the table format provided in Exhibit 4. The purpose of the performance indicator tables is to show progress made over time as measured by the mental health NOMS and any State-selected performance indicators, including the transformation measure(s) selected by the State. The tables are identical to those included in the application for the implementation period, with the following exceptions:

- *Actual* data is required for FY 2008,
- In the section titled "Action Plan," States should describe the strategies and activities the State actually used to address the performance indicator. This section will also highlight *accomplishments* related to the indicator, as well as *any innovative or exemplary model* of mental health service delivery that the State developed that relates to this indicator and the unique features of that model.

- At the end of each indicator's narrative, the report should clearly state whether or not the particular target identified in the State plan for the prior fiscal year for adults with SMI or children with SED was "achieved" or "not achieved." If a target was "not achieved," explain why.

Exhibit 4. Sample Performance Indicator Table for Implementation Report

Name of Performance Indicator:					
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY2006 Actual**	**FY2007 Actual**	**FY2008 Target**	**FY2008 Actual**	**FY2008 % Attained**
Performance Indicator					
Numerator**			---		---
Denominator**			---		---

Table Descriptors:

- **Name of Performance Indicator**: Brief name of the performance indicator (*e.g.*, Increased Access to Services). Clearly label transformation outcome measures.
- **Target**: A specific, measurable, and expected outcome to be achieved within a defined period of time, and, if attained, is expected to contribute to the realization of the goal.
- **Performance Indicator Value:** Numerator divided by Denominator expressed as percentage or actual number if not percentage.

Narrative Elements:

- **Goal**: Broad, general description of what the States hopes to accomplish.
- **Target**: A specific, measurable, and expected outcome to be achieved within a defined period of time, and, if attained, is expected to contribute to the realization of the goal.
- **Population:** Group targeted by this goal.
- **Criterion:** One or more of the five statutory criteria related to this goal.

- **Indicator**: Description of the indicator.
- **Measure**: Specify whether the indicator is measured by number or percentage.
- **Sources of Information**: Databases from which data was reported.
- **Special Issues**: Any special issues or considerations that relate to the indicator.
- **Significance**: Importance of indicator to the overall State Plan.
- **Action Plan:** Actual strategies and activities used, accomplishments, and innovative or exemplary models. (if any)
- **Target Achieved or Not Achieved**: If not, include an explanation of why it was not achieved.

PART E. Uniform Data on the Public Mental Health System

This section guides States in the reporting of uniform data on public mental health services in the State (with a special focus on community mental health services) in a series of data tables.

A. Background of CMHS Uniform Reporting System

In response to the need for accountability for the expenditure of MHBG funds, CMHS and the States have worked in partnership since 1997 to ensure the uniform reporting of State-level data to describe the public mental health system and the outcomes of its programs. The intent of this effort is to make it possible to (1) track individual State performance over time; and (2) aggregate State information to develop a national picture of State public mental health systems.

In order to satisfy the requirement for uniformity of data definitions, the CMHS Uniform Reporting System (URS) was developed. The URS consists of a set of standardized tables that State Mental Health Authorities submit each year as part of their Implementation Report. The data requested in the tables described in this Section answer five basic questions:

(1) What are the mental health service needs of the population in your State?
(2) Who in your State gets access to publicly funded mental health services?
(3) What types of services are being provided in your State?

(4) What are the outcomes of the services provided?

(5) What financial resources are expended for the services?

The data tables are used to calculate the mental health NOMS for State and national reporting. The URS also includes prevalence estimates related to the needs for mental health services within each State.

The URS is a critical tool for State Mental Health Authorities in planning and administering their mental health system. To improve the capacity of the States to collect and report this data, CMHS has provided States with Data Infrastructure Grants (DIGs). These are described in more detail in Part A, Section III (B) of this guidance.

The reporting effort demonstrates that the State public mental health systems provide mental health services to nearly 6 million persons each year. Data from the URS has shown that persons served by the SMHA systems are more often unemployed, receiving Medicaid assistance, and are frequently children and young adults. Persons served by State Mental Health Authorities are most often served in community mental health settings and generally rate their access, appropriateness, and outcomes of services as positive. In FY 2005, State Mental Health Authorities spent nearly $30 billion to provide mental health services.

B. Requirements for Data Submission and Analysis

The completion of Part E is a term and condition for funding for States that were awarded Data Infrastructure Grants (DIGs). *All States that accepted the grant agreed to submit Part E as part of the Implementation Report.* States that did not receive a DIG are encouraged to submit data under Part E of this guidance.

The following requirements pertain to all data submitted:

- To ensure uniformity, the data reported shall be based on the data definitions agreed to in the Mental Health Data Infrastructure Project.

- States are requested to report data based on the last completed fiscal year.
- All client data will be aggregated at the State level. No individual client data is requested or should be submitted to CMHS.
- State identifiers are required for each table.

CMHS, working with its contractor, the National Association of State Mental Health Program Directors (NASMHPD) National Research Institute, Inc. (NRI), will create all derived measures from the primary data provided by the States. CMHS will also review the State-submitted data and make requests for revision, clarification, or additional information as appropriate from the State Mental Health Authorities. After the final review and analysis of the data is completed, CMHS will make State-by-State data profiles available, as well as summary tables that examine performance across all States for selected data elements.

C. Revisions to Tables in the Uniform Reporting System (URS)

There are no significant changes in the URS Tables for FY 2009 – 2011 except that States are no longer required to complete Table 18. Table 18 was intended to produce a profile of adults with schizophrenia receiving new generation medications during the year. However, a review of all URS Tables that included a survey of States determined that this table, which is not used to calculate any SAMHSA NOM, was one of the most difficult for States to report. In addition, the data reported on the table are not comparable across States and are not useful to CMHS or States in planning and improving systems. Table 18 continues to be available to States that elect to submit this data.

For complete information and instructions for completing each URS table, States are encouraged to consult the State Data Infrastructure Coordinating Center (SDICC) website at: http://www.nri-inc.org/projects/SDICC.

Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that _____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[21] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2009, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

[21]. The term State shall hereafter be understood to include Territories.

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:
(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.
(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date

Attachment B. Certifications

http://www.mhbg.samhsa.gov/certification.pdf

Attachment C. Disclosure of Lobbying Activities

http://www.mhbg.samhsa.gov/disclosure.pdf

Attachment D. Assurances

http://www.mhbg.samhsa.gov/assurance.pdf

Attachment E. Face Sheet

FACE SHEET

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

_____ FY 2009 _____ 2009 – 2010 _____ FY 2009 - 2011

STATE NAME: _____ DUNS #: _____

I. AGENCY TO RECEIVE GRANT

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: _____ TITLE: _____

AGENCY _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE:_____ ZIP: _____

TELEPHONE: _____ FAX: _____

III. STATE FISCAL YEAR

FROM: _____ _____ TO: _____ _____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: _____ TITLE: _____

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____ EMAIL: _____

Appendix I. Guidance for Reporting NOMS

This guidance describes the specific numerator and denominator that should be used to report for each mental health NOM. As indicated below, each numerator and denominator is derived from a specific URS table. SAMHSA and the States currently are collaborating in an ongoing effort to refine the specific components of several URS tables in order to improve the quality of information reported by the States. SAMHSA will provide information and instructions to the States to reflect any changes to the URS tables or NOMS that result from this effort.

For complete information and instructions for completing each URS table, see the State Data Infrastructure Coordinating Center (SDICC) website at: http://www.nri-inc.org/projects/SDICC.

1. Increased Access to Services

Mental Health Indicator: Number of Persons Served

This NOM provides an historical perspective of how State systems improve access to services over time for people with SMI and SED. Data to report this NOM is derived from **Tables 2A and 2B**.

States should enter the total number of persons served and targets for the fiscal year(s) covered by the application. If the number of persons served is not available, the State should enter the projected number of persons served. A separate numerator and denominator will not be required for this NOM.

2. Reduced Utilization of Psychiatric Inpatient Beds

States should report two indicators, as described in the guidance below. Data to report this NOM is derived from **URS Table 20A**:

A. Mental Health Indicator: Decreased Rate of Civil Readmissions to State Psychiatric Hospitals Within 30 Days

Numerator	Number of civil readmissions to any state hospital within 30 days
Denominator	*Total number of civil discharges in the year*

B. Mental Health Indicator: Decreased Rate of Civil Readmissions to State Psychiatric Hospitals Within 180 Days

Numerator	Number of civil readmissions to any state hospital within 180 days
Denominator	*Total number of civil discharges in the year*

3. Use of Evidence-Based Practices (EBPs)

States should report multiple indicators, as described in the guidance below. Data to report this NOM is derived from **URS Tables 16 and 17**.

A. Mental Health Indicator: Number of Clients Receiving EBPs

States should report separately for *each* of the EBPs identified in Tables 16 and 17 that is offered in the State. If a State does not offer a specific EBP, the State should indicate that the table is ***not applicable***. The denominator is derived from URS Table 16.

Adult EBP:

Numerator	Number of adults with SMI receiving the specific EBP
Denominator	*Total un-duplicated number of adults with SMI served by the SMHA*

1. Number of Persons with SMI Receiving Supported Housing.
2. Number of Persons with SMI Receiving Supported Employment.
3. Number of Persons with SMI Receiving Assertive Community Treatment.
4. Number of Persons with SMI Receiving Family Psychoeducation.
5. Number of Persons with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA).
6. Number of Persons with SMI Receiving Medication Management.

Child EBP:

Numerator	Number of children with SED receiving the specific EBP
Denominator	*Total un-duplicated number of children with SED served by the SMHA*

1. Number of Persons with SED Receiving Therapeutic Foster Care.
2. Number of Persons with SED Receiving Multi-Systemic Therapy.
3. Number of Persons with SED Receiving Family Functional Therapy.

B. Mental Health Indicator: Number of EBPs Offered

States do not need to provide data for this indicator. CMHS will calculate the indicator based on State responses to Mental Health Indicator 3A (above). Please note that this indicator is designed to demonstrate the number of specific EBPs offered in each State (not the number of EBP programs, locations, or clients).

4. Client Perception of Care

Data to report this NOM is derived from **URS Table 11**. As indicated below, this indicator should be calculated separately for the Adult and Children's Plans.

A. Mental Health Indicator: Percent of Adult Consumers Reporting Positively About Outcomes

Numerator	Number of adult consumers reporting positively about outcomes
Denominator	*Total number of adult consumer responses regarding perceptions of outcomes*

B. Mental Health Indicator: Percent of Families Reporting Positively About Outcomes

Numerator	Number of families reporting positively about outcomes (see data for Child/Adolescent Consumer Survey Results)
Denominator	*Total number of family responses regarding perceptions of outcomes (see data for Child/Adolescent Consumer Survey Results)*

5. Increased/Retained Employment or Return to/Stay in School

States should report two indicators, as described in the guidance below.

A. Mental Health Indicator: Percent of Adult Clients Who are Competitively Employed

Data to report this NOM is derived from **URS Table 4**:

Numerator	Number of adult clients competitively employed full or part-time (includes Supported Employment)
Denominator	*Number of adults competitively employed full or part-time (includes Supported Employment) plus number of persons unemployed plus number of persons not in the labor force (includes retired, sheltered employment, sheltered workshops, and other)* ***Note: This excludes persons whose employment status was "Not Available."***

B. Mental Health Indicator: Percent of Parents Reporting Improvement in Child's School Attendance

Data to report this NOM is derived from **URS Table 19B**:

Numerator	Number of parents reporting improvement in child's school attendance (both new and continuing clients)
Denominator	*Total responses (including Not Available) (new and continuing clients combined)*

6. Decreased Criminal Justice Involvement

Data to report this NOM is derived from **URS Table 19A**. As indicated below, this indicator should be calculated separately for the Adult and Children's Plans.

A. Mental Health Indicator: Percent of Adult Consumers Arrested in Year 1 Who Were Not Re-arrested in Year 2

Numerator	Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined)
Denominator	*Number of adult consumers arrested in T1 (new and continuing clients combined)*

B. Mental Health Indicator: Percent of Children/Youth Consumers Arrested in Year 1 Who Were Not Re-arrested in Year 2

Numerator	Number of children/youth consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined)
Denominator	*Number of children/youth consumers arrested in T1 (new and continuing clients combined)*

7. Increased Stability in Housing

Data to report this NOM is derived from **URS Table 15**. As indicated below, this indicator should be calculated separately for the Adult and Children's Plans.

A. Mental Health Indicator: Percent of Adult Clients Who are Homeless or Living in Shelters

Numerator	Number of adult clients who are homeless or living in shelters
Denominator	*All adult clients with living situation excluding persons with Living Situation Not Available*

B. Mental Health Indicator: Percent of Child/Adolescent Clients Who are Homeless or Living in Shelters

Numerator	Number of child/adolescent clients who are homeless or living in shelters
Denominator	*All child/adolescent clients with living situation excluding persons with Living Situation Not Available*

8. Increased Social Supports/Social Connectedness

Data to report this NOM is derived from **URS Table 9**. Note that this indicator should be calculated separately for the Adult and Children's Plans.

A. Mental Health Indicator: Percent of Adult Consumers Reporting Positively About Social Connectedness

Numerator	Number of adult consumers reporting positively about social connectedness
Denominator	*Total number of adult consumer responses regarding social connectedness*

B. Mental Health Indicator: Percent of Families Reporting Positively About Social Connectedness

Numerator	Number of families of child/adolescent consumers reporting positively about social connectedness
Denominator	*Total number of family responses regarding social connectedness*

9. Improved Level of Functioning

Data to report this NOM is derived from **URS Table 9**. Note that this indicator should be calculated separately for the Adult and Children's Plans.

A. Mental Health Indicator: Percent of Adult Consumers Reporting Positively About Functioning

Numerator	Number of adult consumers reporting positively about functioning
Denominator	*Total number of adult consumer responses regarding functioning*

B. Mental Health Indicator: Percent of Families Reporting Positively About Functioning

Numerator	Number of families of child/adolescent consumers reporting positively about functioning
Denominator	*Total number of family responses regarding functioning*

Appendix II. Uniform Reporting System (URS) Guidelines and Tables

URS Guidelines

Scope of Reporting:

Based on the discussions by State workgroups and input provided by state representatives during the regional conference calls, guidelines have been developed for the scope of reporting. A basic tenet is that the "scope" will represent the mental health "system" that comes under the auspices of the state mental health agency.

This approach resulted in concern regarding comparisons that might be made across states that might have disparate mandates and dissimilar systems. After much discussion, the decision regarding scope was that representation of the state mental health agency system was more critical than comparability across states. The principle proposed was that there needed to be common understanding that these data could not be used to compare states but could be used to track a state's performance across time and to produce U.S. totals.

Major points of discussion were how persons served under Medicaid and through support of local dollars would be counted. For both these areas, persons would be counted insofar as they were considered part of the state mental health agency system and received services from programs funded or operated by the state mental health agency. Persons would be counted if they could be identified and had received a face-to-face service in the reporting period.

More specifically, the following guidelines should be used for including and counting people in the URS:

1 Include all persons served directly by the state mental health agency (including persons who received services funded by Medicaid).

2 Include all persons in the system for whom the state mental health agency contracts for services (including persons whose services are funded by Medicaid).

3 Include any other persons who are counted as being served by the state mental health agency or come under the auspices of the state mental health agency system. This includes Medicaid waivers, if the mental health component of the waiver is considered to be part of the SMHA system.

4 Count all identified persons who have received mental health services, including screening, assessment, and crisis services. Telemedicine services should be counted if they are provided to identify clients.

5 For states where a separate state agency is responsible for children's mental health, where feasible, efforts should be made to un-duplicated clients between the child mental health agency and the adult mental health agency. If this

induplication is not feasible, please report this potential duplication to indicate there is an overlap between the Age "0-17 group" and the Age "18 and over group" but that there is induplication within each group.

Persons who would not be included in the URS Tables:

1 Persons who just received a telephone contact would not be included, unless it was a telemedicine service to a registered client. Hotline calls to anonymous clients should not be counted.

2 Persons who only received a Medicaid-funded mental health service through a provider who was not part of the SMHA system would not be included.

3 Persons who only received a service through a private provider or medical provider not funded by the SMHA would not be included.

4 Persons with a single diagnosis of substance abuse or mental retardation should not be included. All persons with a diagnosis of mental illness should be counted, including persons with a co-occurring diagnosis of substance abuse or mental retardation.

PLEASE NOTE:

The following tables have been prepared by the CMHS-funded State Data Infrastructure Coordinating Center (SDICC) at the NASMHPD Research Institute, Inc. For additional information about the Reporting Guidelines please contact Bernadette Phelan 703-682-9465 (bernadette.phelan@nri-inc.org or Ted Lutterman at 703-682-9463 (ted.lutterman@nri-inc.org)

Table 1: Profile of the State Population by Diagnosis

This table summarizes the estimates of adults residing within the State with serious mental illness (SMI) and children residing within the state with serious emotional disturbances (SED). The table calls for estimates for two time periods, one for the report year and one for three years into the future. CMHS will provide this data to states based on the standardized methodology developed and published in the Federal Register and the state level estimates for both adults with SMI and children with SED.

Table 1.		
Report Year:		
State Identifier:		
	Current Report Year	**Three Years Forward**
Adults with Serious Mental Illness (SMI)		
Children with Serious Emotional Disturbances (SED)		

Note: This Table will be completed for the States by CMHS.

Table 2A: Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide un-duplicated counts if possible.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.	
Report Year:	
State Identifier	

	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander			White			Hispanic * *use only if data for Table 2b are not*			More Than One Race Reported			Race Not Available		
	F	M	NA	Total	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA
0-12 Years	0	0	0	0																								
13-17 years	0	0	0	0																								
18-20 years	0	0	0	0																								
21-64 years	0	0	0	0																								
65-74 years	0	0	0	0																								
75+ years	0	0	0	0																								
Not Available	0	0	0	0																								
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Are these numbers unduplicated? ☐ Unduplicated ☐ Duplicated: between Hospitals and Community ☐ Duplicated Among Community Programs ☐ Duplicated between children and adults ☐ Other: describe: _____

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	
Comments on Data (Overall):	

Instructions for Tables 2A and 2B:

1 Include all persons served directly by the SMHA (including persons who received services funded by Medicaid).

2 Include all persons in the system served within SMHA service contracts, including services funded by Medicaid.

3 Include any other persons who are counted as being served by the SMHA or come under the auspices of the SMHA. This includes Medicaid waivers, if the mental health component of the waiver is considered to be part of the SMHA system.

4 Count all identified persons who have received a mental health service, including screening, assessment, and crisis services. Telemedicine services should be counted if they are provided to identify consumers.

5 For states, where a separate state agency is responsible for children's mental health, where feasible, efforts should be made to un-duplicate consumers between the child mental health agency and the adult mental health agency. If this un-duplication is not feasible, please report this potential duplication to indicate there is an overlap between the "0 to 17" age group and the "18 and over" group, but that there is un-duplication within each group.

6 The "Hispanic" category on Table 2A allows states who do not currently compile Hispanic Origin as a separate question to report the number of Hispanic consumers served. States that track Hispanic Origin as a separate category should report on Table 2B instead of Table 2A.

Persons not included in the URS tables:

1 Persons who just received a telephone contact would not be included, unless it was a telemedicine service to a registered client. Hotline calls to anonymous consumers are not counted.

2 Persons who only received a Medicaid-funded mental health service through a provider who was not part of the SMHA system would not be included.

3 Persons who only received a service through a private provider or medical provider not funded by the SMHA would not be included.

4 Persons with a single diagnosis of substance abuse or mental retardation should not be included. All persons with a diagnosis of mental illness should be counted, including persons with a co-occurring diagnosis of substance abuse or mental retardation.

CMHS has sent out to the States a notice from the Federal Office of Management and Budget (OMB) regarding how all Federal Agencies must collect race and ethnicity information. The OMB rules allow for two tables as set up on Table 2a and 2b. One focuses on race: White, Black, Asian, Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, Multiple Race, Other Race, and Race Unknown. A separate second table will collect information on Hispanic or Latino Origin. This is the format recommended in the Basic Tables.

The OMB standard is different from the way many states historically compile Race and Ethnicity data in three (3) key areas:

1) Native Hawaiian or other Pacific Islander (NHPI) is a new category that was previously compiled as part of Asian. This NHPI category now needs to be collected separately by states.
2) Multiple Race: Programs now need to allow persons to identify multiple racial categories. Thus, a reporting category of More than one Race needs to be

compiled by SMHAs. OMB specifies that Multiple Race should NOT be collected by adding a "Multiple Race" option, but rather that it should be identified by the selection of multiple racial categories: i.e., the list of White, Asian, Black, Native Hawaiian, and American Indian should allow multiple categories to be selected.

3) Ethnicity: Hispanic or Latino Origin should be compiled separately from the "race" categories collected above. The URS Tables are set up this way with Table 2B and Table 5B collecting data on the number of persons of Hispanic or Latino Origin.

CMHS has discussed the implications of this OMB standard for URS/DIG grants and URS Reporting: The OMB standard means that the 3 categories discussed above must become part of SAMHSA and all other Federal data collection. However, CMHS/SAMHSA realizes that states will need time to modify the reporting categories of race and ethnicity. Therefore, the Year 6 Basic Tables will continue to include an option for states to report "Hispanic" within the "Race" categories on Table 2A (and Table 5A). However, CMHS expects that states will start changing their MIS to reflect the new OMB guidance and will eventually be able to report the new categories.

If a person is identified as a combination of racial groups (e.g., white and black), that person should be counted only once and should be reported in the "more than one race" category.

Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons served would be the total as indicated in Table 2A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.													
Report Year:													
State Identifier:													
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
0 - 12 Years										0	0	0	0
13 - 17 years										0	0	0	0
18 - 20 years										0	0	0	0
21-64 years										0	0	0	0
65-74 years										0	0	0	0
75+ years										0	0	0	0
Not Available										0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (for Race/Ethnicity):													
Comments on Data (Overall):													

Table 3: Profile of Persons Served in the Community Mental Health Setting, State Psychiatric Hospitals and Other Settings

This table provides a profile for the clients that received public funded mental health services in community mental health settings, in state psychiatric hospitals, in other psychiatric inpatient programs, and in residential treatment centers for children.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 3.																				
Report Year:																				
State Identifier:																				
	Age 0-17			Age 18-20			Age 21-64			Age 65+			Age Not Available			Total			
Table 3. Service Setting	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**Total**
Community Mental Health Programs																0	0	0	0
State Psychiatric Hospitals																0	0	0	0
Other Psychiatric Inpatient																0	0	0	0
Residential Treatment Center for Children																0	0	0	0
Comments on Data (for Age):																			
Comments on Data (for Gender):																			
Comments on Data (Overall):																			

Instructions:

1. States that have county psychiatric hospitals that serves as surrogate state hospitals should report persons served in such settings as receiving services in state hospitals.
2. If forensic hospitals are part of the state mental health agency system include them.
3. Persons who receive non-inpatient care in state psychiatric hospitals should be included in the Community MH Program row.
4. Persons who receive inpatient psychiatric care through a private provider or medical provider licensed and/or contracted through the SMHA should be counted in the "Other Psychiatric Inpatient" row. Persons who receive Medicaid funded inpatient services through a provider that is not licensed or contracted by the SMHA should not be counted here.
5. A person who is served in both community settings and inpatient settings should be included in both rows.
6. RTC: CMHS has a standardized definition of RTC for Children: "An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth primarily 17 years old and younger. It has a clinical program that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master's degree or doctorate. The primary reason for the admission of the clients is mental illness that can be classified by DSM-IV codes-other than the codes for mental retardation, developmental disorders, and substance-related disorders such as drug abuse and alcoholism (unless these are co-occurring with a mental illness)."

Table 4: Profile of Adult Clients by Employment Status

This table describes the status of adult clients served in the report year by the public mental health system in terms of employment status. The focus is on employment for the working age population, recognizing, however, that there are clients who are disabled, retired or homemakers, care-givers, etc and not a part of the workforce. These persons should be reported in the "Not in Labor Force" category. This category has two subcategories: retired and other (the totals of these two categories should equal the number in the row for "Not in Labor Force"). Unemployed refers to persons who are looking for work but have not found employment. Data should be reported for clients in non-institutional settings at time of discharge or last evaluation.

Table 4.																
Report Year:																
State Identifier:																
	18-20			**21-64**			**65+**			**Age Not Available**			**Total**			
Adults Served	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Total**
Employed: Competitively Employed Full or Part Time (includes Supported Employment)													0	0	0	0
Unemployed													0	0	0	0
Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)													0	0	0	0
Not Available													0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

How Often Does your State Measure Employment Status? ☐ At Admission ☐ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: describe: _____

What populations are included: ☐ All clients ☐ Only selected groups: describe:

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (Overall):	

Instructions:

1. Employed means competitively employed, part-time or full-time. Supported Employment and transitional employment, where consumer's work in competitive employment situations should be reported as "employed". Informal labor, for cash, i.e. day labor is counted as employed.
2. Sheltered employment should be reported as "Not in Labor Force".
3. Employment status should be reported for persons served in community settings.
4. Latest known status of employment should be reported.

Table 4a: Optional Profile of Adult Clients by Employment Status: by Primary Diagnosis Reported

The workgroup exploring employment found that the primary diagnosis of consumers results in major differences in employment status. The workgroup has recommended that we explore the ability of states to report employment by primary diagnosis and the impact of diagnosis on employment. The workgroup recommended 5 diagnostic clusters for reporting:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 4.					
Report Year:					
State Identifier:					
Clients **Primary Diagnosis**	**Employed: Competitively Employed Full or Part Time (includes Supported Employment)**	**Unemployed**	**Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)**	**Employment Status Not Available**	**Total**
Schizophrenia & Related Disorders (295)					**0**
Bipolar and Mood Disorders (296, 300.4, 301.11, 301.13, 311)					**0**
Other Psychoses (297, 298)					**0**
All Other Diagnoses					**0**
No Dx and Deferred DX (799.9, V71.09)					**0**
Diagnosis Total	0	0	0	0	0
Comments on Data (for Diagnosis):					

Table 5A: Profile of Clients by Type of Funding Support

This table provides a summary of clients by Medicaid coverage. Since the focus of the reporting is on clients of the public mental health service delivery system, this table focuses on the clientele serviced by public programs that are funded or operated by the State Mental Health Authority. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid.

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5A																													
Report Year:																													
State Identifier:																													
	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander			White			Hispanic * *use only if data for Table 5b are not available.*			More Than One Race Reported			Race Not Available		
	F	M	NA	Total	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	Female	Male	Not Availa
Medicaid (only Medicaid)	0	0	0	0																									
Non-Medicaid Sources (only)	0	0	0	0																									
People Served by Both Medicaid and Non-Medicaid	0	0	0	0																									
Medicaid Status Not Available	0	0	0	0																									
Total Served	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

☐ Data based on Medicaid Paid Services ☐ Data Based on Medicaid Eligibility, not Medicaid Paid Services ☐ Data are Duplicated

Instructions:

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Not Available).

If a state is unable to un-duplicate between people whose care is paid by Medicaid, then they should report all data into the People Served by Both Medicaid and Other Sources and would check the box, 'People Served by Both is a duplicated count'.

Table 5B: Profile of Clients by Type of Funding Support

Of the total persons covered by Medicaid, please indicate the gender and number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons covered by Medicaid would be the total indicated in Table 5A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5B.													
Report Year:													
State Identifier:													
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Unknown			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
Medicaid Only										0	0	0	0
Non-Medicaid Only										0	0	0	0
People Served by Both Medicaid and Non-Medicaid Sources										0	0	0	0
Medicaid Status Unknown										0	0	0	0
Total Served	0	0	0	0	0	0	0	0	0	0	0	0	0
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (Overall):													

Instructions:

Each row should have a unique (un-duplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Unknown).

If a state is unable to un-duplicate between People whose care is paid by Medicaid, then they should report all data into the People Served by Both Medicaid and Other Sources and would check the box, 'People Served by Both is a duplicated count'.

Table 6: Profile of Client Turnover

This table reflects client flow and turnover.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 6.										
Report Year:										
State Identifier:										
Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions During the year (duplicated)	Discharges During the year (duplicated)	Length of Stay (in Days): Discharged Patients		For Clients in Faclity for Less Than 1 Year: Average Length of Stay (in Days): Residents at end of year		For Clients in Facility More Than 1 Year: Average Length of Stay (in Days): Residents at end of year	
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median
State Hospitals	-	-	-						
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Other Psychiatric Inpatient	-	-	-						
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Residential Tx Centers	-	-	-						
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Community Programs	-	-							
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Comments on Data (State Hospital):									
Comments on Data (Other Inpatient):									
Comments on Data (Residential Treatment):									
Comments on Data (Community Programs):									
Comments on Data (Overall):									

Instructions:

1. Column 1 represents an un-duplicated count of all persons all persons receiving services at the start of the reporting period. This includes all persons who are on the active books as patients at the start of the year.
2. Column 2 represents all additions or new admissions during the reporting period. If a person has multiple admissions during that reporting period, all admissions will be counted.
3. As in Table 2, there may be duplication across age categories, depending on the state's ability to un-duplicate between children and adult systems of care.
4. Column 3 represents all discharges during the reporting period. If a person has multiple discharges during that reporting period, all discharges will be counted.
5. As in table 3, there may be duplication across the state hospital section and the community section.
6. Length of Stay for clients in facility more than 1-year column: this column should be used to report persons in hospital for **over** a year (persons in the hospital for exactly 1 year should be reported in the prior columns of persons in hospital for less than one year).
7. The "Adults" category under "Residential Treatment Centers" (RTC) was added to this table in 2006 to allow reporting of use of RTCs by adults (18 years and over). This category was added because several states reported that their RTCs for Children had some persons age 18 or over in them and they lacked a place to report them. (The intent of allowing reporting of adults in RTC-Children was not to open a new reporting category of residential settings for adults, but to allow states with adults in RTC-C to report those adults).

Table 7: Profile of Mental Health Service Expenditures and Sources of Funding

This table describes expenditures for public mental health services provided or funded by the State mental health agency by source of funding.

This Table will be completed by the NASMHPD Research Institute (NRI) using data from the FY 2005 SMHA-Controlled Revenues and Expenditures Study

Table 7.				
Report Year:				
State Identifier:				
	State Hospital	**Other 24 Hour Care***	**Ambulatory/ Community Non-24 Hour Care**	**Total**
Total	**Data will come from the NRI's FY'2005 SMHA Revenues and Expenditures Study.**			
Medicaid				
Community MH Block Grant				
Other CMHS				
Other Federal (non-CMHS)				
State				
Other				

** Other 24 Hour Care: is "residential care" from both state hospitals and community ("Ambulatory/Community). Thus, "Other 24 Hour Care" expenditures are also included in the state hospital and/or "Ambulatory/Community" Columns as applicable.*

Note: The data in this table are derived from the National Association of State Mental Health Program Directors Research Institute, Inc. State Mental Health Agency-Controlled Revenues and Expenditures Study. FY2005 Data for this table is currently being compiled by the NRI.

Table 8: Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities

This table is used to describe the use of CMHS BG funds for non-direct service activities that are sponsored, or conducted, by the State Mental Health Authority.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 8	
Report Year:	
State Identifier:	
Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities	
Service	**Estimated Total Block Grant**
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	**$0**
Comments on Data:	

Instructions:

1. States should only report on the expenditures of the CMHBG by the SMHA or programs that they directly contract with.
2. States should not report on expenditures by programs more than one-level down from the State in funding: e.g., if a state provides CMHBG funds to county mental health authorities, which in turn contract with private, not-for-profit mental health providers, only the expenditures by the SMHA and the county mental health authorities should be reported in this table.

Table 9: SAMHSA NOMS: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 9: NOMS Social Connectedness & Functioning			
Report Year (Year Survey was Conducted):			
State Identifier:			
Adult Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
1. Social Connectedness			
2. Functioning			
Child/Adolsecent Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
3. Social Connectedness			
4. Functioning			
Comments on Data:			

Adult Social Connectedness and Functioning Measures

1. Did you use the recommended new Social Connectedness Questions? ☐ Yes ☐ No _____ Measure used
2: Did you use the recommended new Functioning Domain Questions? ☐ Yes ☐ No _____ Measure used

3. Did you collect these as part of your MHSIP Adult Consumer Survey? ☐ Yes ☐ No

If No, what source did you use?

Child/Family Social Connectedness and Functioning Measures

4: Did you use the recommended new Social Connectedness Questions? ☐ Yes ☐ No _____ Measure used
5: Did you use the recommended new Functioning Domain Questions? ☐ Yes ☐ No _____ Measure used

6. Did you collect these as part of your YSS-F Survey? ☐ Yes ☐ No

If No, what source did you use?

Instructions:

Reporting of 2 CMHS National Outcome Measures: Social Connectedness and Functioning.

This Table permits states who implemented the recommended NOMS modules on "Social Connectedness" and/or "Improved Functioning" as part of their 2007 Consumer Surveys to report results for these NOMS.

Recommended Scoring Rules

Please use the same rules for reporting Social connectedness and Functioning Domain scores as for calculating other Consumer Survey Domain scores for Table 11:

1. Recode ratings of "not applicable" as missing values.
2. Exclude respondents with more than 1/3 of the items in that domain missing.
3. Calculate the mean of the items for each respondent.
4. FOR ADULTS: calculate the percent of scores less than 2.5 (percent agree and strongly agree).
5. FOR YSS-F: calculate the percent of scores greater than 3.5 (percent agree and strongly agree).

Items to Score:

Adult MHSIP Social Connectedness Domain:

1. I am happy with the friendships I have.
2. I have people with whom I can do enjoyable things.
3. I feel I belong in my community.
4. In a crisis, I would have the support I need from family or friends.

Adult MHSIP Functioning Domain:

1. I do things that are more meaningful to me.
2. I am better able to take care of my needs.
3. I am better able to handle things when they go wrong.
4. I am better able to do things that I want to do.
5. My Symptoms are not bothering me as much. (already is part of the MHSIP Adult Survey).

YSS-F Social Connectedness Domain Items:

1. I know people who will listen and understand me when I need to talk.
2. I have people that I am comfortable talking with about my child's problems.
3. In a crisis, I would have the support I need from family or friends.
4. I have people with whom I can do enjoyable things.

YSS-F Functioning Domain Items:

1. My child is better able to do things he or she wants to do.
2. My child is better at handling daily life. (existing YSS-F Survey item).
3. My child gets along better with family members. (existing YSS-F Survey item).
4. My child gets along better with friends and other people. (existing YSS-F Survey item).
5. My child is doing better in school and/or work. (existing YSS-F Survey item).
6. My child is better able to cope when things go wrong. (existing YSS-F Survey item).

Note: The YSS-F functioning domain relies on 4 items that are also used in calculating the YSS-F "Outcomes Domain".

Table 10: Profile of Agencies Receiving Block Grant Funds Directly from the SMHA.

This table is to be used to provide an inventory of providers/agencies who directly receive Block Grant allocations**.**
Only report those programs that receive MHBG funds to provide services. Do not report planning council member reimbursements or other administrative reimbursements related to running the MHBG Program.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 10				
Report Year:				
State Identifier:				
Agency Name	**Address**	**Name of Director**	**Phone #**	**Amount of Block Grant Allocation to Agency**

Use one row for each program

* If you need more lines for additional agencies, please add rows or make copies of this table.

Table 11: Summary Profile of Client Evaluation of Care.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 11.			
Report Year (Year Survey was Conducted):			
State Identifier:			
Adult Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Confidence Interval***
1. Reporting Positively About Access.			
2. Reporting Positively About Quality and Appropriateness for Adults			
3. Reporting Positively About Outcomes.			
4. Adults Reporting on Participation In Treatment Planning.			
5. Adults Positively about General Satisfaction with Services.			
Child/Adolsecent Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Confidence Interval***
1. Reporting Positively About Access.			
2. Reporting Positively about General Satisfaction for Children.			
3. Reporting Positively about Outcomes for Children.			
4. Family Members Reporting on Participation In Treatment Planning for their Children			
5. Family Members Reporting High Cultural Sensitivity of Staff.			

**** Please report Confidence Intervals at the 95% level. See directions below regarding the calculation of confidence intervals.***

Comments on Data:

Adult Consumer Surveys

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? ☐ Yes ☐ No

1.a. If no, which version:
- 1. Original 40 Item Version ☐ Yes
- 2. 21-Item Version ☐ Yes
- 3. State Variation of MHSIP ☐ Yes
- 4. Other Consumer Survey ☐ Yes

1.b. If other, please attach instrument used.

1.c. Did you use any translations of the MHSIP into another language? ☐ 1. Spanish

2. Other Language:

Adult Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state) ☐ 1. All Consumers in State ☐ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used? ☐ 1. Random Sample ☐ 2. Stratified Sample ☐ 3. Convenience Sample

4. Other Sample:

Adult Consumer Surveys (Continued)

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?

☐ 1. Persons Currently Receiving Services

☐ 2. Persons No Longer Receiving Services

3. Please Describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)

☐ 1. All Adult consumers in state
☐ 2. Adults with Serious Mental Illness
☐ 3. Adults who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes	☐ Yes
Mail	☐ Yes	
Face-to-face	☐ Yes	☐ Yes
Web-Based	☐ Yes	☐ Yes

4.b. Who administered the Survey? (Check all that apply)

☐ 1. MH Consumers
☐ 2. Family Members
☐ 3. Professional Interviewers
☐ 4. MH Clinicians
☐ 5. Non Direct Treatment Staff
6. Other: describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

☐ 1. Responses are Anonymous
☐ 2. Responses are Confidential
☐ 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?
6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses)
6.c How many surveys were completed? (survey forms returned or calls completed)
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)
6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates? ☐ Yes ☐ No

7. Who Conducted the Survey

7.a. SMHA Conducted or contracted for the Survey (survey done at state level) ☐ Yes ☐ No
7.b. Local Mental Health Providers/County mental heatlh providers conducted or contracted for the survey (survey was done at the local or regional level) ☐ Yes ☐ No
7.c. Other: Describe:

* Report Confidence Intervals at the 95% confidence level

confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had asked the question of the entire relevant population between 43% (47-4) and 51% (47+4) would have picked that answer.
The confidence level tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population

Child/Family Consumer Surveys

1. Was the MHSIP Children/Family Survey (YSS-F) Used? ☐ Yes ☐ No
If no, please attach instrument used.

1.c. Did you use any translations of the Child MHSIP into another language? ☐ 1. Spanish
2. Other Language: _____

Child Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state) ☐ 1. All Consumers in State ☐ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used? ☐ 1. Random Sample ☐ 2. Stratified Sample ☐ 3. Convenience Sample

4. Other Sample: _____

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?
☐ 1. Persons Currently Receiving Services
☐ 2. Persons No Longer Receiving Services

2a. If yes to 2, please describe how your survey persons no longer receiving services.

3. Please Describe the populations included in your sample: (e.g., all children, only chidlren with SED, etc.)
☐ 1. All Child consumers in state
☐ 2. Children with Serious Emotional Disturbances
☐ 3. Children who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes	☐ Yes
Mail	☐ Yes	
Face-to-face		☐ Yes
Web-based	☐ Yes	☐ Yes

4.b. Who administered the Survey? (Check all that apply)
☐ 1. MH Consumers
☐ 2. Family Members
☐ 3. Professional Interviewers
☐ 4. MH Clinicians
☐ 5. Non Direct Treatment Staff
6. Other: describe: _____

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?
☐ 1. Responses are Anonymous
☐ 2. Responses are Confidential
☐ 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?	
6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses)	
6.c How many surveys were completed? (survey forms returned or calls completed)	
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates? ☐ Yes ☐ No

7. Who Conducted the Survey
7.a. SMHA Conducted or contracted for the Survey (survey done at state level) ☐ Yes ☐ No
7.b. Local Mental Health Providers/County mental heatlh providers conducted or contracted for the survey (survey was done at the local or regional level) ☐ Yes ☐ No
7.c. Other: Describe: _____

Instructions:

1) Scoring of domains: States should use the approach for calculating domain scores developed for the 16-State Study and 5-State Study. Domain scores should only be calculated using surveys that had 2/3 or more of the items complete for that domain.

2) Report the number of "positive" responses and the total number of responses for each domain instead of just collecting the percent responding positive, i.e., instead of reporting 75% positive, states would report they had received 75 positive responses and 100 total responses for that domain. The reason for the collection of numbers is it will allow better analysis of data across states and at national levels.

3) States should report confidence intervals at the domain level. In year 1, states were asked to report confidence intervals for the overall survey. However, it was discussed that actual confidence levels should be calculated for each domain, since each domain may have a different number of valid responses. Confidence intervals should be reported at the 95% level. Directions on how to calculate confidence intervals are included on Table 11, along with a website that will assist states in this calculation.

4) Question 1 on the use of the MHSIP consumer survey: if a state or program conducted the MHSIP consumer survey using the wording from the "official" 28 item adult MHSIP survey, then the state should check that they used the official version. If a state added additional questions to the survey, but added them after the original 28 items, then they are still doing the official MHSIP survey. However, if a state modified the wording of the official 28-item MHSIP, or added questions in the middle of the 28 items, then the state should check that they did a "state variation of MHSIP).

5) Sample Approach: Question 2a: A random sample is a sample where everyone has an equal chance of being selected and the person doing the selection has no way of choosing who is selected. A state that surveys all consumers or all consumers in a particular program is not conducting a random sample. The options are: 1) random, 2) stratified random sample 3) convenience 4) all consumers.

Adult Consumer Surveys:

The MHSIP Survey is the preferred instrument to compile results. The official 28 Item version of MHSIP is the recommended version. If some other version of the MHSIP Survey is used, individual items should be combined to calculate indicator scores using the questions listed below. CMHS, the MHSIP Policy Group, and the DIG Consumer Survey Workgroup also recommend reporting of data for the two optional factors from the full 28 Item MHSIP Survey: Participation in Treatment Planning and General Satisfaction.

The following are recommendations that relate to the Adult Survey:

1) Statewide Surveys: States should only report consumer survey results from surveys that are conducted on a statewide basis – preferably surveys conducted with a "scientific" sampling technique.
   a) States that only have pilot data or only data from a few providers or a region of the state should not report data.
   b) States should use a centrally conducted survey – i.e., individual community providers should not each conduct their own surveys with the state reporting aggregate results.
   c) States should describe their sampling methodology when they submit data.

2) Sample Size: a sufficient sample size ("n") should be collected for surveys to be reported. States are requested to report the confidence interval and confidence levels for their surveys. States should use a sufficient sample size to report results at high confidence levels.

3) Specific Questions to Use: Based on the assumption that most states (currently over 40 states) are using either the official 28 item MHSIP Consumer Survey, or a variant of the MHSIP Consumer Survey, the Workgroup recommends states report results based on the official 28 survey items used by the 16 State Study for calculating scores for the 5 domains. (2 domains are optional).

a) MHSIP Consumer Survey: **Perception of Access**.
   i) The location of services was convenient.
   ii) Staff was willing to see me as often as I felt it was necessary.
   iii) Staff returned my calls within 24 hours.
   iv) Services were available at times that were good for me.
   v) I was able to get all the services I thought I needed. *
   vi) I was able to see a psychiatrist when I wanted to. *

b) MHSIP Consumer Survey: **Perception of Quality and Appropriateness**.
   i) Staff believed that I could grow, change and recover.
   ii) I felt free to complain.
   iii) Staff told what side effects to watch for.
   iv) Staff respected my wishes about who is and is not to be given information about my treatment.
   v) Staff was sensitive to my cultural/ethnic background.
   vi) Staff helped me obtain the information needed so I could take charge of managing my illness.
   vii) I was give information about my rights.
   viii) Staff encouraged me to take responsibility for how I live my life. *
   ix) I was encouraged to use consumer-run programs. *

c) MHSIP Consumer Survey: **Perceptions of Outcomes:**
   i) I deal more effectively with daily problems.
   ii) I am better able to control my life.
   iii) I am better able to deal with crisis.
   iv) I am getting along better with my family.
   v) I do better in social situations.
   vi) I do better in school and/or work.
   vii) My symptoms are not bothering me as much.
   viii) My housing situation has improved. *

d) MHSIP Consumer Survey: **Perception of Participation in Treatment Planning** (Optional).
   i) I felt comfortable asking questions about my treatment and medications.
   ii) I, not staff, decided my treatment goals.

e) MHSIP Consumer Survey: **General Satisfaction**. (Optional).
   i) I liked the services that I received here.
   ii) If I had other choices, I would still get services at this agency.
   iii) I would recommend this agency to a friend or family member.

f) New Module for **Social Connectedness**. (reported on Table 9).
   i) I am happy with the friendships I have.

ii) I have people with whom I can do enjoyable things.
iii) I feel I belong in my community.
iv) In a crisis, I would have the support I need from family or friends.

g) New Module for Adult MHSIP **Functioning** Domain: (reported on Table 9).
i) I do things that are more meaningful to me.
ii) I am better able to take care of my needs.
iii) I am better able to handle things when they go wrong.
iv) I am better able to do things that I want to do.
v) My Symptoms are not bothering me as much. (Note: This question is used in both the "Outcomes Domain" and the "Functioning Domain").

* Items noted with an * are items from the full 28 Item Adult MHSIP Consumer Survey that should be used to calculate domain scores. Items marked with an * were not used in the 16 State Study. States that do not have the full 28 Items from the Official MHSIP Consumer Survey should report results based on those items in each domain that they have.

Scoring:

1. Recode ratings of "not applicable" as missing values.
2. Exclude respondents with more than 1/3 of the items in that domain missing.
3. Calculate the mean of the items for each respondent.
4. Calculate the percent of scores less than 2.5. (Percent agree and strongly agree).

Additional reporting to add to Table 11:

- The workgroup has suggested adding an **optional** reporting of consumer survey results by consumer characteristics.
- States should report Consumer Survey Results for each domain by Race/ethnicity in addition to the Total rate currently requested in Table 11.
- States should use the same categories as in other URS Tables.
- Patient categories should not be cross tabs: e.g., report results for age, then for race, not age by race.
- States should only report results for patient categories when there are at least 25 or 30 subjects in the category, i.e., do not report results for very small "n" categories.

Children/Adolescent Consumer Surveys:

The workgroup recommends using the Family version (YSS-F) for reporting on Table 11. If states want to conduct the adolescent survey (YSS), that would be reported as an option. This would require adding a third column to Table 11 to accommodate the second child survey.

Questions for each Domain for the YSS-F Survey are as follows:

Good Access to Service:

- The location of services was convenient for us.
- Services were available at times that were convenient for us.

Satisfaction with Services:

- Overall, I am satisfied with the services my child received.
- The people helping my child stuck with us no matter what.
- I felt my child had someone to talk to when he/she was troubled.
- The services my child and/or family received were right for us.
- My family got the help we wanted for my child.
- My family got as much help as we needed for my child.

Positive Outcomes of Services:

- My child is better at handling daily life.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is doing better in school and/or work.
- My child is better able to cope when things go wrong.
- I am satisfied with our family life right now.

Participation in Treatment:

- I helped to choose my child's services.
- I helped to choose my child's treatment goals.
- I was frequently involved in my child's treatment.

Cultural Sensitivity:

- Staff treated me with respect.
- Staff respected my family's religious/spiritual beliefs.
- Staff spoke with me in a way that I understood.
- Staff were sensitive to my cultural/ethnic background.

New YSS-F Social Connectedness Domain Items: (reported on Table 9)

1. I know people who will listen and understand me when I need to talk.
2. I have people that I am comfortable talking with about my child's problems.
3. In a crisis, I would have the support I need from family or friends.
4. I have people with whom I can do enjoyable things.

New YSS-F Functioning Domain Items: (reported on Table 9)

1. My child is better able to do things he or she wants to do.
2. My child is better at handling daily life. *(also used for the YSS-F "Outcomes Domain").*
3. My child gets along better with family members. *(also used for the YSS-F "Outcomes Domain").*
4. My child gets along better with friends and other people. *(also used for the YSS-F "Outcomes Domain").*
5. My child is better able to cope when things go wrong. *(also used for the YSS-F "Outcomes Domain").*

Note: the calculation of the YSS-F "Functioning Domain" uses many of the survey items that are also used for the "Outcomes Domain".

Scoring:

1. Exclude respondents with more missing values than allowed per factor:
2. Calculate the mean of the items for each respondent.
3. Calculate the percent of scores greater than 3.5 (percent agree and strongly agree).

Numerator: Total number of respondents with an average scale score > 3.5.
Denominator: Total number of respondents.

Table 11a: Consumer Evaluation of Care by consumer Characteristics: (Optional Table by Race/Ethnicity.)

Table 11a.	
Report Year:	
State Identifier:	

Adult Consumer Survey Results:

*State used the 2 question version for Hispanic Origin ○ Yes ○ No

Please check the appropriate box on the left. The "Totals" formula will automatically adjust to account for which method your state used to ask about Hispanic Origin/Status

Indicators	Total		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Other Pacific Islander		White		More than One Race Reported		Other/ Not Available		Hispanic Origin*	
Adult Consumer Survey Results:	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
1. Reporting Positively About Access.																		
2. Reporting Positively About Quality and Appropriateness.																		
3. Reporting Positively About Outcomes.																		
4. Reporting Positively about Participation in Treatment Planning																		
5. Reporting Positively about General Satisfaction																		
6. Social Connectedness																		
7. Functioning																		

Child/Adolescent Family Survey Results:

*State used the 2 question version for Hispanic Origin ○ Yes ○ No

Please check the appropriate box on the left. The "Totals" formula will automatically adjust to account for which method your state used to ask about Hispanic Origin/Status

Indicators	Total		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Other Pacific Islander		White		More than One Race Reported		Other/ Not Available		Hispanic Origin*	
Child/Adolescent Family Survey Results:	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
Reporting Positively About Access.																		
Reporting Positively About General Satisfaction																		
Reporting Positively About Outcomes.																		
Reporting Positively Participation in Treatment Planning for their Children.																		
Reporting Positively About Cultural Sensitivity of Staff.																		
6. Social Connectedness																		
7. Functioning																		

Comments on Data:

Please enter the number of persons responding positively to the questions and the number of total responses within each group. Percent positive will be calculated from these data.

Table 12: State Mental Health Agency Profile

The purpose of this profile is to obtain information that provides a context for the data provided in the tables. This profile covers the populations served, services for which the state mental health agency is responsible, data reporting capacities, especially related to duplication of numbers served as well as certain summary administrative information.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 12	
Report Year:	
State Identifier:	

Populations Served

1 Which of the following populations receive services operated or funded by the state mental health agency? Please indicate if they are included in the data provided in the tables. (Check all that apply.)

	Populations Covered		Included in Data	
	State Hospitals	Community Programs	State Hospitals	Community Programs
1. Aged 0 to 3	☐ Yes	☐ Yes	☐ Yes	☐ Yes
2. Aged 4 to 17	☐ Yes	☐ Yes	☐ Yes	☐ Yes
3. Adults Aged 18 and over	☐ Yes	☐ Yes	☐ Yes	☐ Yes
4. Forensics	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Comments on Data:				

2 Do all of the adults and children served through the state mental health agency meet the Federal definitions of serious mental illness and serious emotional disturbances?

☐ Serious Mental Illness
☐ Serious Emotional Disturbances

2.a. If no, please indicate the percentage of persons served for the reporting period who met the federal definitions of serious mental illness and serious emotional disturbance?

2.a.1	Percent of adults meeting Federal definition of SMI:	
2.a.2	Percentage of children/adolescents meeting Federal definition of SED	

3 Co-Occurring Mental Health and Substance Abuse:

3.a.	What percentage of persons served by the SMHA for the reporting period have a dual diagnosis of mental illness and substance abuse?	
3.a.1	Percentage of adults served by the SMHA who also have a diagnosis of substance abuse problem:	
3.a.2.	Percentage of children/adolescents served by the SMHA who also have a diagnosis of substance abuse problem:	
3.b.	What percentage of persons served for the reporting period who met the Federal definitions of adults with SMI and children/adolescents with SED have a dual diagnosis of mental illness and substance abuse.	
3.b.1	Percentage of adults meeting Federal definition of SMI who also have a diagnosis of substance abuse problem:	
3.b.2.	Percentage of children/adolescents meeting the Federal definition of SED who also have a diagnosis of substance abuse problem:	
3b.3	Please describe how you calculate and count the number of persons with co-occurring disorders	

4 State Mental Health Agency Responsibilities

a. Medicaid: Does the State Mental Health Agency have any of the following responsibilities for mental health services provided through Medicaid? (Check All that Apply)

1. State Medicaid Operating Agency	☐
2. Setting Standards	☐
3. Quality Improvement/Program Compliance	☐
4. Resolving Consumer Complaints	☐
5. Licensing	☐
6. Sanctions	☐
7. Other	

	b. Managed Care (Mental Health Managed Care		Are Data for these programs reported on URS Tables?
4.b.1	Does the State have a Medicaid Managed Care initiative?	☐ Yes	☐ Yes
4.b.2	Does the State Mental Health Agency have any responsibilities for mental health services provided through Medicaid Managed Care?	☐ Yes	☐ Yes
	If yes, please check the responsibilities the SMHA has:		
4.b.3	Direct contractual responsibility and oversight of the MCOs or BHOs	☐ Yes	
4.b.4	Setting Standards for mental health services	☐ Yes	
4.b.5	Coordination with state health and Medicaid agencies	☐ Yes	
4.b.6	Resolving mental health consumer complaints	☐ Yes	
4.b.7	Input in contract development	☐ Yes	
4.b.8	Performance monitoring	☐ Yes	
4.b.9	Other		

5 **Data Reporting: Please describe the extent to which your information systems allows the generation of unduplicated client counts between different parts of your mental health system. Please respond in particular for Table 2, which requires unduplicated counts of clients served across your entire mental health system.**

Are the data reporting in the tables?

5.a. **Unduplicated** :counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas. ☐

5.b. **Duplicated:** across state hospital and community programs ☐

5.c. **Duplicated:** within community programs ☐

5.d. **Duplicated:** Between Child and Adult Agencies ☐

5.e. **Plans for Unduplication:** If you are not currently able to provide unduplicated client counts across all parts of your mental health system, please describe your plans to get unduplicated client counts by the end of your Data Infrastructure Grant.

6 Summary Administrative Data

6.a.	Report Year	
6.b.	State Identifier	
	Summary Information on Data Submitted by SMHA:	
6.c.	Year being reported: From:	to
6.d.	Person Responsible for Submission	
6.e.	Contact Phone Number:	
6.f.	Contact Address	
6.g.	E-mail:	

Table 13: Profile of Unmet Needs of the State Population

This table provides estimates of adults with serious mental illness and children with serious emotional disturbances that have unmet service needs. This table is to be completed based on a standardized unmet needs estimation methodology being developed by the Center for Mental Health Services. CMHS will provide the methodology for estimating unmet needs to each State.

Table 13.		
Report Year:		
State Identifier:		
	Current Report Year	**Three Years Forward**
Adults with Serious Mental Illness (SMI)	***Note Table is Still being Operationally Defined Do not report data in 2005***	***Note Table is Still being Operationally Defined Do not report data in 2005***
Children with Serious Emotional Disturbances (SED)	***Note Table is Still being Operationally Defined Do not report data in 2005***	***Note Table is Still being Operationally Defined Do not report data in 2005***

Issue: Note States should not report data for this indicator in 2007. SAMHSA [has stated that they] will provide this estimation methodology for states.

The Workgroup for this Table will be working with CMHS on a proposed methodology. The Workgroup is currently focusing on estimating **the number of persons likely to use public services who are unserved?** (i.e., count of persons near the poverty level (~200%) with a SMI who are not served minus count of persons served in the public mental health system).

Table 14A: Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

This is a developmental table similar to Table 2A and 2B. This table requests counts for persons with SMI or SED using the definitions provided by the CMHS. Table 2A and 2B included all clients served by publicly operated or funded programs. This table counts only clients who meet the CMHS definition of SMI or SED. For many states, this table may be the same as Tables 2A and 2B. States should report using the Federal Definitions of SMI and SED if they can report them, if not, please report using your state's definitions of SMI and SED and provide the requested information at the bottom of the table describing your state's definition.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 14A.	
Report Year:	
State Identifier:	

	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific			White			Hispanic **use only if data for Table 14b are*			More Than One Race Reported			Race Not Available		
	F	M	NA	Total	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA
0-12 Years	0	0	0	0																								
13-17 years	0	0	0	0																								
18-20 years	0	0	0	0																								
21-64 years	0	0	0	0																								
65-74 years	0	0	0	0																								
75+ years	0	0	0	0																								
Not Available	0	0	0	0																								
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	
Comments on Data (Overall):	

1. State Definitions Match the Federal Definitions:

☐ Yes ☐ No Adults with SMI, if No describe or attach state definition: _____

Diagnoses included in state SMI definition: _____

☐ Yes ☐ No Children with SED, if No describe or attach state definition: _____

Diagnoses included in state SED definition: _____

Table 14B: Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who meet the Federal definition of SMI and SED and who are Hispanic/Latino or not Hispanic/Latino. The total persons served who meet the Federal definition of SMI or SED should be the total as indicated in Table 14 A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 14B.													
Report Year:													
State Identifier:													
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Available	Female	Male	Available	Female	Male	Available	Female	Male	Available	Total
0 - 12 Years										0	0	0	0
13 - 17 years										0	0	0	0
18 - 20 years										0	0	0	0
21-64 years										0	0	0	0
65-74 years										0	0	0	0
75+ years										0	0	0	0
Not Available										0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (for Race/Ethnicity):													
Comments on Data (Overall):													

Table 15: Living Situation Profile:

Number of Clients in Each Living Situation as Collected by the Most Recent Assessment in the Reporting Period. All Mental Health Programs by Age, Gender, and Race/Ethnicity.

This table provides an aggregate profile of persons served in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client's last known Living Situation. Please provide un-duplicated counts, if possible.

Table 15.											
Report Year:											
State Identifier:											
	Private Residence	**Foster Home**	**Residential Care**	**Crisis Residence**	**Children's Residential Treatment**	**Institutional Setting**	**Jail/ Correctional Facility**	**Homeless/ Shelter**	**Other**	**NA**	**Total**
0-17											0
18-64											0
65 +											0
Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
Female											0
Male											0
Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
American Indian/Alaska Native											0
Asian											0
Black/African American											0
Hawaiian/Pacific Islander											0
White/Caucasian											0
Hispanic *											0
More than One Race Reported											0
Race/Ethnicity Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
Hispanic or Latino Origin											0
Non Hispanic or Latino Origin											0
Hispanic/Latino Origin Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
Comments on Data:											

How Often Does your State Measure Living Situation? ☐ At Admission ☐ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: describe:

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Living Situation Definitions:

Private Residence: Individual lives in a house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO).

Foster Home: Individual resides in a Foster Home. A Foster Home is a home that is licensed by a County or State Department to provide foster care to children, adolescents, and/or adults. This includes Therapeutic Foster Care Facilities. Therapeutic Foster Care is a service that provides treatment for troubled children within private homes of trained families.

Residential Care: Individual resides in a residential care facility. This level of care may include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, or Rehabilitation Center, or Agency-operated residential care facilities.

Crisis Residence: A residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores clients to a pre-crisis level of functioning. These programs are time limited for persons until they achieve stabilization. Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting.

Children's Residential Treatment Facility: Children and Youth Residential Treatment Facilities (RTF's) provide fully integrated mental health treatment services to seriously emotionally disturbed children and youth. An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth. The services are provided in facilities, which are certified by state or federal agencies or through a national accrediting agency.

Institutional Setting: Individual resides in an institutional care facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a Skilled Nursing/Intermediate Care Facility, Nursing Homes, Institutes of Mental Disease (IMD), Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, or State Hospital.

Jail/ Correctional Facility: Individual resides in a Jail and/or Correctional facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a Jail, Correctional Facility, Detention Centers, Prison, Youth Authority Facility, Juvenile Hall, Boot Camp, or Boys Ranch.

Homeless: A person should be counted in the "Homeless" category if he/she was reported homeless at their most recent (last) assessment during the reporting period (or at discharge for patients discharged during the year). The "last" Assessment could occur at Admission, Discharge, or at some point during treatment. A person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residency is:

A) A supervised publicly or privately operated shelter designed to provide temporary living accommodations,
B) An institution that provides a temporary residence for individuals intended to be institutionalized, or
C) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).

Not Available: Information on an individual's residence is not available.

Table 16: Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 16.								
Report Year:								
State Identifier:								
	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Distrubance (SED)			
	n Receiving Supported Housing	n Receiving Supported Employment	n Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI served	n Receiving Thereaputic Foster Care	n Receiving Multi-Systemic Therapy	n Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Age								
0-12								
13-17								
18-20								
21-64								
65-74								
75+								
Not Available								
TOTAL	0	0	0	0	0	0	0	0
Gender								
Female								
Male								
Not Available								
Race/Ethnicity								
American Indian/Alaska Native								
Asian								
Black/African American								
Hawaiian/Pacific Islander								
White								
Hispanic*								
More than one race								
Not Available								
Hispanic/Latino Origin								
Hispanic/Latino Origin								
Non Hispanic/Latino								
Not Available								
Do You monitor fidelity for this service?	Yes / No ☐ ☐	Yes / No ☐ ☐	Yes / No ☐ ☐		Yes / No ☐ ☐	Yes / No ☐ ☐	Yes / No ☐ ☐	
IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								
How often is fidelity measured?								
	Yes / No	Yes / No	Yes / No		Yes / No	Yes / No	Yes / No	
Is the SAMHSA EBP Toolkit used to guide EBP Implementation?	☐ ☐	☐ ☐	☐ ☐		☐ ☐	☐ ☐	☐ ☐	
Have staff been specifically trained to implement the EBP?	☐ ☐	☐ ☐	☐ ☐		☐ ☐	☐ ☐	☐ ☐	

* Hispanic is part of the total served. ◯ Yes ◯ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

DATA INFRASTRUCTURE GRANTS

Guidelines for Reporting Evidence-Based Practices

Table 16: Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services:

Table 17: Profile of Adults with Serious Mental Illnesses Receiving Specific Services during the Year:

PURPOSE

The purpose of this document is to provide guidelines for reporting evidence-based practices (EBPs) on the Uniform Reporting System (URS) that is part of SAMHSA's Center for Mental Health Services (CMHS) Community Mental Health Block Grant Reporting. Up to this point, guidelines have been relatively broad: states have elected to report their activities in the evidence-based practices categories if they were providing services that conformed to the definitions provided. In some cases, states that were implementing EBPs with fidelity did not report data because they thought that comparisons with states (or the national averages produced) that were not implementing the EBP with fidelity could be interpreted negatively. In other cases, states that were not monitoring fidelity chose not to report. The purpose of these guidelines is to help states assess whether their particular services align with the critical components of specific EBPs for DIG reporting.

DEVELOPMENT OF GUIDELINES

To get data that were more systematically uniform and that conformed better with the evidence-based form of the practice, CMHS charged the DIG Coordinating Center to convene a sub-group of state representatives to develop a set of guidelines for reporting EBPs recognizing that many states were not monitoring fidelity for many of the EBPs.

That is, at this stage, requiring fidelity was considered too stringent and restrictive for purposes of reporting EBPs on the URS tables. Many states are currently moving forward with the implementation of EBPs and the objective of these guidelines is to facilitate reporting of these state activities. The charge to the group essentially was to develop guidelines based on fidelity that could remove some of the ambiguity of what could be counted under this category.

To proceed with this task, a subset of state representatives involved with the Data Infrastructure Grants initiative was identified as the EBP workgroup. They convened several times on conference calls; draft recommendations were presented and reviewed by all states on the regional monthly DIG calls. Based on these activities, draft guidelines that are provided in this report were developed.

> Note: In no sense are these intended to be a revised definition of the practice or an identification of a new set of fidelity measures or critical elements. These guidelines are to help states identify whether they should report their activities in these tables or not. The intent is to obtain information if states are moving forward with implementation of the evidence-based form of the practice.

USE OF GUIDELINES FOR DIG REPORTING

As stated above, the intent of these guidelines is to provide guidance for states to decide whether they should report data on EBPs. They are not intended to be prescriptive or to set inflexible boundaries, but to indicate whether the services being reported conform broadly to the evidence-based practices. As reporting takes place, these guidelines are expected to be revised and refined over time.

ASSERTIVE COMMUNITY TREATMENT

I. DEFINITION

A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomized effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, "Adults and Mental Health, Service Delivery, Assertive Community Treatment"). Additionally, CMS (formerly HCFA) recommended that state Medicaid agencies consider adding the service to their State Plans in HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations, June 07, 1999.

II. FIDELITY MEASURE http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/

III. MINIMUM REQUIREMENTS FOR REPORTING ACT

- Small caseload: Client/ provider ratio of 10:1 or fewer is the ideal.
- Multidisciplinary team approach: This is a team approach rather than an approach which emphasizes services by individual providers. The team should be multidisciplinary and could include a psychiatrist, nurse, substance abuse specialist. For reporting purposes, there should be at least 3 FTE on the team.
- Includes clinical component: In addition to case management, the program directly provides services such as: psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/ rehabilitative services.
- Services provided in community settings: Program works to monitor status, develop community living skills in the community rather than the office.
- Responsibility for crisis services: Program has 24-hour responsibility for covering psychiatric crises.

IV. ACT IS NOT INTENSIVE CASE MANAGEMENT

Note: If specific EBPs are provided as a component of ACT, they should be reported under ACT and not separately under other practices. In the revised version of the tables, please check off the EBPs that are provided under ACT. (Please note that to report these as EBPs; they should conform to the reporting guidelines for each EBP provided in this document.)

SUPPORTED EMPLOYMENT

I. DEFINITION

Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illnesses. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

II. FIDELITY MEASURE http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED EMPLOYMENT

- Competitive employment: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.

- Integration with treatment: Employment specialists are part of the mental health treatment teams with shared decision-making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.

- Rapid job search: The search for competitive jobs occurs rapidly after program entry.

- Eligibility based on consumer choice (not client characteristics): No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms.

- Follow–along support: Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and, networked supports (friends/family).

IV. SUPPORTED EMPLOYMENT IS NOT:

- Prevocational training.
- Sheltered work.
- Employment in enclaves. (that is in settings, where only people with disabilities are employed).
- [If an employment specialist is part of an ACT team, this should be reported under ACT and not separately as supported employment.]

SUPPORTED HOUSING

I. DEFINITION

Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assists clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

II. FIDELITY MEASURE (Not currently available).

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED HOUSING

- Target population: Targeted to persons who would not have a viable housing arrangement without this service.
- Staff assigned: Specific staff are assigned to provide supported housing services.
- Housing is integrated: That is, supported housing provided for living situations in settings that are also available to persons who do not have mental illnesses.
- Consumer has the right to tenure: The ownership or lease documents are in the name of the consumer.
- Affordability: Supported housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.

IV. SUPPORTED HOUSING IS NOT:

- Residential treatment services.
- A component of case management or ACT.

FAMILY PSYCHO-EDUCATION

I. DEFINITION

Family psycho-education is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psycho-education programs may be either multi-family or single-family focused. Core characteristics of family psycho-education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

II. FIDELITY MEASURE http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/

III. MINIMUM REQUIREMENTS FOR REPORTING FAMILY PSYCHO-EDUCATION

- A structured curriculum is used.
- Psycho-education is a part of clinical treatment.

IV. FAMILY PSYCHO-EDUCATION IS NOT:

Several mechanisms for family psycho-education exist. The evidence-based model, promoted through SAMHSA's EBP implementation resource kit ("toolkit") involves a clinician. For DIG reporting, do not include family psycho-education models not involving a clinician as part of clinical treatment.

> Note: Some states are providing NAMI's Family-to-Family program and not the family psycho-education EBP described above. If a state is providing NAMI's Family-to-Family program, this should be reported under family psycho-education with an asterisk and a note indicating that the numbers reflect the NAMI program and not the EBP described above.

INTEGRATED TREATMENT FOR CO-OCCURRING DISORDER (MENTAL HEALTH / SUBSTANCE ABUSE)

I. DEFINITION

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

II. FIDELITY MEASURE http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/

III. MINIMUM REQUIREMENTS FOR REPORTING INTEGRATED TREATMENT

- Multidisciplinary team: A team of clinical, working in one setting provides MH and SA interventions in a coordinated fashion.

- Stage-wise interventions: That is, treatment is consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention).

IV. INTEGRATED TREATMENT IS NOT:

- Coordination of clinical services across provider agencies.

ILLNESS MANAGEMENT / RECOVERY

I. DEFINITION

Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness, strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

II. FIDELITY MEASURE http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/

III. MINIMUM REQUIREMENTS FOR REPORTING ILLNESS MANAGEMENT & RECOVERY

- Service includes a specific curriculum that includes mental illness facts, recovery strategies, using medications, stress management and coping skills. It is critical that a specific curriculum is being used for these components to be counted for reporting.

IV. EVIDENCE-BASED ILLNESS MANAGEMENT IS NOT:

- Advice related to self-care but a comprehensive, systematic approach to developing an understanding and a set of skills that help a consumer be an agent for his or her own recovery.

MEDICATION MANAGEMENT

I. DEFINITION

In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management.
2. Objective measures of outcome are produced.
3. Documentation is thorough and clear.
4. Consumers and practitioners share in the decision-making.

II. FIDELITY MEASURE http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/

III. MINIMUM REQUIREMENTS FOR REPORTING MEDICATION MANAGEMENT

- Treatment plan specifies outcome for each medication.
- Desired outcomes are tracked systematically using standardized instruments in a way to inform treatment decisions.
- Sequencing of antipsychotic medication and changes are based on clinical guidelines.

IV. EVIDENCE-BASED MEDICATION MANAGEMENT IS NOT:

- Medication prescription administration that occurs without the minimum requirements specified above.

MULTISYSTEMIC THERAPY (MST)

I. DEFINITION

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

II. FIDELITY MEASURE

Contact Jeanne Rivard at 703-682-9468 or Jeanne.rivard@nri-inc.org

III. MINIMUM REQUIREMENTS

- Services take into account the life situation and environment of the child / adolescent and involve peers, school staff, parents, etc.
- Services are individualized.
- Services are provided by MST Therapists or masters-level professional.
- Services are time-limited.
- Services are available 24/7.

THERAPEUTIC FOSTER CARE

I. DEFINITION

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed."

II. FIDELITY MEASURE Contact Jeanne Rivard at 703-682-9468 or Jeanne.rivard@nri-inc.org)

III. MINIMUM REQUIREMENTS FOR REPORTING

- There is an explicit focus on treatment.
- There is an explicit program to train and supervise treatment foster parents.
- Placement is in the individual family home.

IV. THERAPEUTIC FOSTER CARE IS NOT:

- An enhanced version of regular foster care.

FUNCTIONAL FAMILY THERAPY (FFT)

I. DEFINITION

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

II. FIDELITY MEASURE Contact Jeanne Rivard at 703-682-9468 or Jeanne.rivard@nri-inc.org)

III. MINIMUM REQUIREMENTS

- Services are provided in phases related to engagement, motivation, assessment, behavior change, etc.
- Services are short-term, ranging from 8-26 hours of direct service time
- Flexible delivery of service by one and two person teams to clients in-home, clinic, juvenile court, and at time of re-entry from institutional placement.

INSTRUCTIONS for Table 16

1. Please enter the unduplicated number of adults with serious mental illness and children with serious emotional disturbances who received each service category during the reporting year.

2. Please enter the unduplicated number of adults with serious mental illness and children with SED served in each of the age, sex and race/ethnicity categories during the reporting period.

3. States are using a variety of instruments to monitor fidelity, some of which are more standardized than others. If fidelity is being monitored in your state, please indicate the instrument being used for each service category.

Table 17: Profile of Adults with Serious Mental Illnesses Receiving Specific Services during the Year:

Table 17.				
Report Year:				
State Identifier:				
	ADULTS WITH SERIOUS MENTAL ILLNESS			
	Receiving Family Psychoeducation	Receiving Integrated Treatment for Co-occurring Disorders (MH/SA)	Receiving Illness Self Management	Receiving Medication Management
Age				Provisional Pending Review by OMB: Please Report if Possible
18-20				
21-64				
65-74				
75+				
Not Available				
TOTAL	0	0	0	0
Gender				
Female				
Male				
Not Available				
Race				
American Indian/ Alaska Native				
Asian				
Black/African American				
Hawaiian/Pacific Islander				
White				
Hispanic*				
More than one race				
Unknown				
Hispanic/Latino Origin				
Hispanic/Latino Origin				
Non Hispanic/Latino				
Hispanic origin not available				

Do You monitor fidelity for this service?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								
How often is fidelity measured?								
	Yes	No	Yes	No	Yes	No	Yes	No
Is the SAMHSA EBP Toolkit used to guide EBP Implementation?	☐	☐	☐	☐	☐	☐	☐	☐
Have staff been specifically trained to implement the EBP?	☐	☐	☐	☐	☐	☐	☐	☐

* Hispanic is part of the total served. ◯ Yes ◯ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

INSTRUCTIONS for Table 17

1. Please enter the unduplicated number of adults with serious mental illness who received each service category during the reporting year.

2. Please enter the unduplicated number of adults with serious mental illness (or children with SED) in each age, sex and race/ethnicity category that received any service during the year.

3. States are using a variety of instruments to monitor fidelity, some of which are more standardized than others. If fidelity is being monitored in your state, please indicate the instrument being used for each service category.

PLEASE NOTE:
States Are Not Required to Complete or Submit Table 18

Table 18: Profile of Adults with Schizophrenia Receiving New Generation Medications During The Year

Table 18.						
Report Year:						
State Identifier:						
	STATE HOSPITALS		**COMMUNITY SETTINGS**		**STATE MENTAL HEALTH SYSTEM**	
	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served
Age						
18-20						
21-64						
65-74						
75+						
Not Available						
TOTAL	0	0	0	0	0	0
Gender						
Female						
Male						
Not Available						
Race						
American Indian/ Alaska Native						
Asian						
Black/African American						
Hawaiian/Pacific Islander						
White						
Hispanic*						
More than one race						
Unknown						
Hispanic/Latino Origin						
Hispanic/Latino Origin						
Non Hispanic/Latino						
Hispanic origin not available						
Are specific clinical guidelines followed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
If Yes, which one?						

* Hispanic is part of the total served. ○ Yes ○ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

INSTRUCTIONS for Table 18

1 Please enter the unduplicated number of adults with schizophrenia that received the new generation medications in each setting.

2 Please enter the unduplicated number of all adults with a primary diagnosis of schizophrenia that received any service in the specified setting during the year.

3 Some clinical guidelines used:

- American Psychiatric Association.
- Consensus "Tri-University" Project.
- Schizophrenia Patient Outcome Research Team (PORT).
- Texas Medications Algorithm Project (TMAP).

DEFINITIONS

Adults with Schizophrenia Receiving New Generation Medications: Adults with a primary diagnosis of schizophrenia who received aripiprazole (Abilify), clozapine, quetiapine, olanzapine, risperidone or ziprasidone during the reporting year in the specified setting.

Table 19A. Profile of Criminal Justice or Juvenile Justice Involvement

1. This is a developmental measure. To assist in the development process, we are asking states to report information on the arrest histories of mental health consumers with their December 2007 MHBG submission.

2. The SAMHSA National Outcome Measure for Criminal Justice measures the change in Arrests over time. The DIG Outcomes Workgroup pilot tested 3 consumer self-report items that can be used to provide this information. If your state has used the 3 Consumer self-report items on criminal justice, you may report them here.

3. If your SMHA has data on Arrest records from alternatives sources, you may also report that here. If you only have data for arrests for consumers in this year, please report that in the T2 columns. If you can calculate the change in Arrests from T1 to T2, please use all those columns.

4. Please complete the check boxes at the bottom of the table to help explain the data sources that you used to complete this table.

5. Please tell us anything else that would help us to understand your indicator (e.g., list survey or MIS questions; describe linking methodology and data sources; specify time period for criminal justice involvement; explain whether treatment data are collected).

Table 19A. Profile of Adult Criminal Justice and Youth Juvenile Justice Contacts

State: _____ **Time period in which services were received:** _____

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change						Assessment of the Impact of Services					
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Arrested at T1 (Prior 12 Months)			If Not Arrested at T1 (Prior 12 Months)			Over the last 12 months, my encounters with the police have…					
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# Reduced (fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	No Response	Total Responses
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Children/Youth (under age 18)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male																		
Female																		
Gender NA																		
Total Adults (age 18 and over)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male																		
Female																		
Gender NA																		

For Consumers Who Began Mental Health Services during the past 12 months

	T1			T2			T1 to T2 Change						Assessment of the Impact of Services					
	"T1" 12 months prior to beginning services			"T2" Since Beginning Services (this year)			If Arrested at T1 (Prior 12 Months)			If Not Arrested at T1 (Prior 12 Months)			Since starting to receive MH Services, my encounters with the police have…					
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# Reduced (fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	No Response	Total Responses
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Children/Youth (under age 18)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male																		
Female																		
Gender NA																		
Total Adults (age 18 and over)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male																		
Female																		
Gender NA																		

See Page 2 for additional Questions about the source of this data.

Please Describe the Sources of your Criminal Justice Data

Source of adult criminal justice information: __ 1) Consumer survey (recommended questions __ 2) Other Consumer Survey: Please send copy of questions __ 3) Mental health MIS
__ 4) State criminal justice agency __ 5) Local criminal justice agency __ 6) Other (specify) _____

Sources of children/youth criminal justice information: __ 1) Consumer survey (recommended questions __ 2) Other Consumer Survey: Please send copy of questions __ 3) Mental health MIS
__ 4) State criminal/juvenile justice agency __ 5) Local criminal/juvenile justice agency __ 6) Other (specify) _____

Measure of adult criminal justice involvement: __ 1) Arrests __ 2) Other: specify

Measure of children/youth criminal justice involvement: __ 1) Arrests __ 2) Other: specify

Mental health programs included: __ 1) Adults with SMI only __ 2) Other adults (specify) _____ __ 3) Both (all adults)
__ 1) Children with SED only __ 2) Other Children (specify) _____ __ 3) Both (all Children)

Region for which adult data are reported: ___ 1) The whole state ___ 2) Less than the whole state (please describe)

Region for which children/youth data are reported: ___ 1) The whole state ___ 2) Less than the whole state (please describe)

What is the Total Number of Persons Surveyed or for whom Criminal Justice Data Are Reported

	Child/Adolescents	Adults
1. If data is from a survey, What is the total Number of people from which the sample was drawn?		
2. What was your sample size? (How many individuals were selected for the sample)?		
3. How many survey Contacts were made? (surveys to valid phone numbers or addresses)		
4. How many surveys were completed? (survey forms returned or calls completed) If data source was not a Survey, How many persons were CJ data available for?		
5. What was your response rate? (number of Completed surveys divided by number of Contacts):		

State Comments/Notes:

Instructions:

If you have responses to a survey by person not in the expected age group, you should include those responses with other responses from the survey. e.g. if a 16 or 17 year old responds to the Adult MHSIP survey, please include their responses in the Adult categories (since that was the survey they used).

Table 19B: Profiles of Change in School Attendance

1. This is a developmental measure. To assist in the development process, we are asking states to report information on the school attendance outcomes of mental health consumers with their December 2007 MHBG submission.

2. The SAMHSA National Outcome Measure for School Attendance measures the change in days attended over time. The DIG Outcomes Workgroup pilot tested 3 consumer self-report items that can be used to provide this information. If your state has used the 3 Consumer Self-Report items on School Attendance, you may report them here.

3. If your SMHA has data on School Attendance from alternatives sources, you may also report that here. If you only have data for School attendance for consumers in this year, please report that in the T2 columns. If you can calculate the change in Attendance from T1 to T2, please use all these columns.

4. Please complete the check boxes at the bottom of the table to help explain the data sources that you used to complete this table.

5. Please tell us anything else that would help us to understand your indicator (e.g., list survey or MIS questions; describe linking methodology and data sources; specify time period for criminal justice involvement; explain whether treatment data are collected).

Table 19b. Profile of Change in School Attendance

State: _____ **Time period in which services were received:** _____

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change						Impact of Services					
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Suspended at T1 (Prior 12 Months)			If Not Suspended at T1 (Prior 12 Months)			Over the last 12 months, the number of days my child was in school have					
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	No response	Total Responses
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gender																		
Male																		
Female																		
Gender NA																		
Age																		
Under 18																		

For Consumers Who Began Mental Health Services during the past 12 months

	T1			T2			T1 to T2 Change						Impact of Services					
	"T1" 12 months prior to beginning services			"T2" Since Beginning Services (this year)			If Suspended at T1 (Prior 12 Months)			If Not Suspended at T1 (Prior 12 Months)			Since starting to receive MH Services, the number of days my child was in school have					
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	No response	Total Responses
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gender																		
Male																		
Female																		
Gender NA																		
Age																		
Under 18																		

See Page 2 for additional Questions about the source of this data.

Table 19b. Profile of Change in School Attendance

Source of School Attendance Information	__ 1) Consumer survey (recommended items)	__ 2) Other Survey: Please send us items	__ 3) Mental health MIS
	__ 4) State Education Department	__ 5) Local Schools/Education Agencies	__ 6) Other (specify) _____
Measure of School Attendance	__ 1) School Attendance	__ 2) Other: _____	
Mental health programs include:	__ 1) Children with SED only	__ 2) Other Children (specify) _____	__ 3) Both.
Region for which data are reported:	___ 1) The whole state	___ 2) Less than the whole state (please describe)	

What is the Total Number of Persons Surveyed or for whom School Attendance Data Are Reported

	Child/Adolescents
1. If data is from a survey, What is the total Number of people from which the sample was drawn?	
2. What was your sample size? (How many individuals were selected for the sample)?	
3. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	
4. How many surveys were completed? (survey forms returned or calls completed) If data source was not a Survey, How many persons were data available for?	
5. What was your response rate? (number of Completed surveys divided by number of Contacts):	

State Comments/Notes	

Note these are still developmental:

These tables have been designed to allow states that have implemented the new Consumer Survey Modules for Criminal Justice and School Attendance to report results by age and gender.

If you did not use the new consumer survey modules, but have administrative data available for these indicators, you may use these tables to submit this data. If your state has administrative data for arrests or school attendance, please report arrests this year, in the cells for "T2 Most Recent 12 Months" and arrests in the prior year under T1: Prior 12 months".

The DIG/URS workgroup on Outcome Measures will be analyzing the information submitted this year. Therefore, we would like as complete information as possible about your information sources for these tables. Please use the check boxes and footnote spaces to tell us additional information about how you collected data for this indicator.

Changed for 2007:

1. "No Response" columns were added to the "T1 to T2 Change and "Assessment of the Impact of Services" categories for both Tables 19a and 19b.
2. The sources of criminal justice data section of this table has been updated to allow states to provide separate answers for adults and children/youth.

URS DEVELOPMENTAL TABLES: 20A, 20B, and 21: READMISSION TO ANY STATE PSYCHIATRIC INPATIENT HOSPITAL WITHIN 30/180 DAYS OF DISCHARGE

Table 20A: Readmissions of Non-Forensic Patients to Any State Psychiatric Hospitals within 30/180 Days of Discharge

Table 20B: Readmissions of Forensic Patients to Any State Psychiatric Hospitals within 30/180 Days of Discharge

Table 21: Readmissions to Any Psychiatric Inpatient Unit within 30/180 Days of Discharge

RATIONALE FOR USE: A major outcome of the development of a community-based system of care is expected to be reduced utilization of state and county-operated psychiatric inpatient beds and better coordination of care between hospitals and community mental health systems. The goal is to decrease the number of consumers who are readmitted to psychiatric inpatient care within 30 and 180 days of being discharged.

APPROACH TO MEASURE: The total number of admissions to any state psychiatric inpatient care that occurred within 30 and 180 days of a discharge from a psychiatric inpatient care during the past year divided by the total number of discharges during the year.

Percent readmitted is derived by dividing the number of episodes of readmission by the total number of discharges during a year in a state. Percent readmitted is presented by state, and for age, gender, race, and Hispanic/Latino Origin.

Since admissions and discharges of Forensic Patients are usually determined by the courts, rather than the SMHA, there is a separate table (Table 20B) for reporting the readmission experiences of Forensic Patients.

MEASURE(S):

Table 20A and 20B Numerator: The number of readmissions to a state operated psychiatric hospital inpatient unit within a specified time period after discharge. Readmitted is defined as returned to any state hospital without contingency; this would exclude those who were not discharged, including on leave, visits, leaves without consent, and elopements. Persons who are discharged for the purpose of receiving medical treatment in another facility who return to the state psychiatric hospital should not be counted as a readmission when they return to the psychiatric hospital.

Optional Table 21 Numerator: The number of readmissions to either a state psychiatric hospital or Other Psychiatric Inpatient Hospital bed in programs that are funded by the SMHA (part of the SMHA system and reported on Table 3 as Other Psychiatric Hospitals).

Denominator: The total number of discharges from a state operated psychiatric hospital inpatient unit (not unduplicated). Discharged is defined as released from the hospital without contingency; this would exclude those who are released on leave, including visits, leaves without consent, discharges for medical treatment.

Optional Table 21 Denominator: The total number of discharges from a state operated psychiatric hospital inpatient unit or other psychiatric hospital inpatient unit (not unduplicated). Discharged is defined as released from the hospital without contingency; this would exclude those who are released on leave, including visits, leaves without consent, discharges for medical treatment.

Data Note: For the 30-day readmission rate the numerator is based on readmissions in a 13-month period. For the 180-day readmission rate, the numerator is based on readmissions in an 18-month period.

ISSUES:

When reporting by age categories, if there are different ages between the first admission and the readmission, use the discharge age from the first admission.

Ideally, this indicator would be expanded to include all readmissions to any hospital, not just state psychiatric hospitals. With the increased use of local general hospital psychiatric units, it will become important over time to expand this indicator beyond the current focus on state psychiatric hospitals.

DEFINITION:

FORENSIC CLIENTS: are mental health consumers who come to the mental health system due to their contact with the criminal justice systems. Specific forensic activities may include, but are not limited to: a) diagnosis of individuals placed in an inpatient unit for short-term psychiatric observation; b) provision of diagnostic and treatment support for correctional populations on an inpatient basis; providing security up to maximum levels; and provision of security staff in secure units for the rehabilitation and management of behaviorally problematic individuals. Forensic patients include:

NGRI/GBMI: "Not guilty by reason of insanity" (NGRI) and/or "guilty but mentally ill" (GBMI) have been referred by legal and law enforcement agencies for emergency psychiatric evaluations; and persons who are to be evaluated for dangerousness. Provision of Forensic services may occur within any of the separate state psychiatric hospital services, other hospital programs, community-based programs, and/or through the SMHA administrative offices.

COMPETENCY: Defendants who are detained and evaluated as to their mental competence to stand trial.

TRANSFERS FROM CRIMINAL JUSTICE/JUVENILE JUSTICE: Services to adult or juvenile prisoners who have been transferred to the state hospital to receive services.

SEXUALLY VIOLENT PREDATORS: An increasing population in many state mental health systems is persons deemed to be "Sexually Violent Predators". These persons have been convicted of a sexual offence and been sent to the mental health system for treatment and control.

Table 20A. Profile of Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20A.					
Report Year:					
State Identifier:					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	0	0	0		
Age					
0-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					

Are Forensic Patients Included? ◯ Yes ◯ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 20B. Profile of Forensic Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20B.					
Report Year:					
State Identifier:					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	0	0	0		
Age					
0-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					
Comments on Data:					

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 21. Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 21.					
Report Year:					
State Identifier:					
	Total number of Discharges in Year	Number of Readmissions to ANY Psychiatric Inpatient Care Unit Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	0	0	0		
Age					
0-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					

1. Does this table include readmission from state psychiatric hospitals?	☐ Yes	☐ No
2. Are Forensic Patients Included?	☐ Yes	☐ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 20A, 20B, and 21 – Questions and Answers

I. Several states asked about whom should they count - only persons served in the community; only persons served in state hospitals; or all persons?

Answer: *This indicator focuses on the persons who are served in the state hospitals and thus are the persons who are reported on URS Basic Table 3 and Table 6 as served in the state hospital during the year.*

II. What about Other Psychiatric Inpatient Programs? Should they be reported?

Answer: *The Optional Table 21 for this indicator compiles information on persons who are served in the other psychiatric inpatient programs reported on URS Basic Table 3b and Table 6. Persons served in these programs would only be reported on the Optional Table 21, not on Table 20 (which focuses on state psychiatric hospitals).*

III. Should the 30 and 180-day readmissions be unduplicated or duplicated (e.g., during the readmissions within 30/180 days of discharges, is it 0-30 days and 31-180 days or is it 0-30 days and 0-180 days thus making the 0-30 day group a subset of the 0-180 group to some degree)?

Answer: *The 16 State Study calculated them as 0-30 and 0-180 days, thus making the 0-30 days group a subset of the 0-180 day measure. Since the 16 State Study group conceived of the 180 day measure as a separate indicator of care (measuring community tenure), it is desirable to calculate the 0-180 rate as a complete rate and not have to add the 31-180 day numbers together with the 0-30 day numbers to calculate the desired rate.*

IV. If we split out the forensics, how are we determining who is a forensic readmission? Are we looking at their forensic status at discharge and readmission, just discharge or just readmission? There are four possible combinations of forensic status

Answer: *If a person's forensic status or age changes between their discharge and their readmission, it is recommended that you report them in the category from their last discharge. This is consistent with the 16 State Study that recommended that states use the discharge client status, since that was thought to be more reliable (coming at the end of a hospital stay) than the readmission status.*

V. Optional Table 21: Other Psychiatric Hospital Inpatient readmissions: Should the Optional Table include only readmissions to non-state psychiatric hospitals, or should the table include all readmissions (include data from both state psychiatric hospital readmissions and other psychiatric inpatient readmissions)?

Answer: *The workgroup recommends that states should report the combined data of all readmissions to any psychiatric hospital. Each state should report the data as they can and describe if they are reporting combined data or data that excludes state psychiatric hospitals. Comparisons could be made over time for a single state, and rates can be calculated for output tables that make appropriate national comparisons (e.g., a state that supplied integrated data for both state hospitals and other inpatient would get the national rate of states that reported such data)*

Extra Table: General/Additional Footnotes

Please use this table to enter any general comments and/or additional footnotes. This can be used for both footnotes that did not fit in the Footnotes field for a certain table, or it can be used for comments that apply to several tables, or are general comments for a state.

Comment No.	Re. Table No.	Comment